

9435

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS 4000 Cathedral Avenue, N.W. | |
| 3. NAME OF DECEASED (Type or print) First Clifford Middle Robertson Last Allen | | 4. DATE OF DEATH Month September Day 20 Year 1956 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 26, 1881 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer | | 10b. KIND OF BUSINESS OR INDUSTRY Law | 9. AGE (In years last birthday) 75 yrs. |
| 11. BIRTHPLACE (State or foreign country) Tennessee | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John T. Allen | | 14. MOTHER'S MAIDEN NAME Ella Wilkerson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 577-32-3323 | |
| 17. INFORMANT The Medical Record | | Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure DUE TO 1999 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma to heart from Tongue DUE TO and neck nodes & Rt Lung (c) 5 mos. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH at least 5 mos. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from September 8, 1956 to September 20, 1956 , that I last saw the deceased alive on September 20, 1956 , and that death occurred at 6:37 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Chester Z. Haverback M.D. | | ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | |
| PHYSICIAN'S NAME (Type) Chester Z. Haverback, M. D. | | DATE SIGNED 9/21/56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9/22/56 | 22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | 22d. LOCATION (City, town, or county) (State) Washington D.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Bessie M. Thompson | | 24a. REC'D BY REGISTRAR DATE 9-24-56 | |
| 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9436

CERTIFICATE OF DEATH

Reg. Dist. No. 09495 212

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> | | | | c. LENGTH OF STAY IN 1b <u>20 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>White</u> Last <u>Allnutt</u> | | | | 4. DATE OF DEATH Month <u>Sept</u> Day <u>20</u> Year <u>1956</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 14 - 1875</u> | | 9. AGE (In years last birthday) <u>81</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer owner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Benjamin W. Allnutt</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rachel Ann White</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>1176</u> | | 17. INFORMANT <u>Sam W. Allnutt, Germantown, Md.</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute heart failure</u> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia of prostate</u> DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>20 min</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>William C. Miller</u> M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>7-Brooks av., Gaithersburg, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>William C Miller</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Sept 22-56</u> | | <u>Monocacy</u> | | <u>Beallsville Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hatten, Beallsville, Md</u> ADDRESS | | | | 24a. REC'D BY REGISTRAR DATE <u>9/20/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles W. Elgin</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. 18
 CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| NAME OF DECEASED <i>John Doe</i> | | AGE <i>45</i> | | SEX <i>Male</i> | | RACE <i>White</i> | | DATE OF BIRTH <i>Jan 15 1911</i> | | PLACE OF BIRTH <i>St. Louis, Mo.</i> | |
| MANNER OF DEATH <i>Natural</i> | | CAUSE OF DEATH <i>Heart Disease</i> | | IMMEDIATE CAUSE <i>Myocardial Infarction</i> | | DISEASE OR INJURY <i>Coronary Artery Disease</i> | | DURATION OF ILLNESS <i>2 weeks</i> | | DATE OF DEATH <i>Sept 10 1956</i> | |
| PLACE OF DEATH <i>Home</i> | | RESIDENT OR VISITOR <i>Resident</i> | | OCCUPATION <i>Teacher</i> | | EDUCATION <i>High School</i> | | RELIGION <i>Catholic</i> | | MARITAL STATUS <i>Married</i> | |
| NAME OF PHYSICIAN <i>Dr. J. Smith</i> | | NAME OF HOSPITAL <i>St. Mary's</i> | | NAME OF NURSE <i>Mrs. Jones</i> | | NAME OF ASSISTANT <i>Mr. Brown</i> | | NAME OF ATTENDING <i>Dr. Smith</i> | | NAME OF WITNESS <i>Dr. Jones</i> | |
| SIGNATURE OF PHYSICIAN <i>[Signature]</i> | | SIGNATURE OF HOSPITAL <i>[Signature]</i> | | SIGNATURE OF NURSE <i>[Signature]</i> | | SIGNATURE OF ASSISTANT <i>[Signature]</i> | | SIGNATURE OF ATTENDING <i>[Signature]</i> | | SIGNATURE OF WITNESS <i>[Signature]</i> | |

RECEIVED
 SEP 24 1956
 BUREAU V. E.

Items 18&21 Film G202 9-13-56 ans
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09406
9437 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 Reg. Dist. No. *216*

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5630 Newington Court | | d. STREET ADDRESS 5630 Newington Court | |
| 3. NAME OF DECEASED (Type or print) First EMMA Middle COWAN Last APPLEBY | | 4. DATE OF DEATH Month Sept. Day 2, Year 19 56 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 28-1927 |
| 9. AGE (In years last birthday) 29 yrs. | | IF UNDER 1 YEAR Months 0 Days 4 | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Penna. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Edward G. Strickler | | 14. MOTHER'S MAIDEN NAME Florence Cowan | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Robert H. Appleby | | Address 5630 Newington Ct. Bethesda, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to carbon monoxide poisoning DUE TO (b) Suicide Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-5-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln | | 22d. LOCATION (City, town, or county) (State) Prince Georges Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Md | |
| 24a. REC'D BY REGISTRAR 9-4-56 | | 24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9438

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|--|---|---|---|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Fort Lauderdale | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Lauderdale | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. # 240 | | | | d. STREET ADDRESS 48X-3 | | | |
| 3. NAME OF DECEASED (Type or print) EDNA M. BAKER First Middle Last | | | | 4. DATE OF DEATH September 16, 1956 Month Day Year | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 11, 1895 | | 9. AGE (In years last birthday) 61 yrs. | IF UNDER 1 YEAR Months 6 Days 5 Hours 5 Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) New Jersey | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Jacob Cox | | | | 14. MOTHER'S MAIDEN NAME Mary E. Green | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 579-26-5232 | | 17. INFORMANT A. Raymond Cox- 105 W. Linton St. Philadelphia, Pa. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma metastatic 1999 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 mo. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Washington, D.C. | | (County) | (State) |
| 21. I certify that I attended the deceased from Aug 28, 1956 to Sept 16, 1956 that I last saw the deceased alive on Sept 14, 1956 and that death occurred at 2:15 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Gilbert B. Rude M.D. | | | | ADDRESS (Street, city or town, state) 3900 Military Road, N.W. Washington, D.C. | | | |
| PHYSICIAN'S NAME (Type) Gilbert B. Rude - 3900 Military Road, N.W. Washington, D.C. | | | | DATE SIGNED 9-17-56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-19-56 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington National | | 22d. LOCATION (City, town, or county) (State) Arlington, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey- Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR DATE 9-17-56 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

9411

CERTIFICATE OF DEATH

Reg. Dist. No.

223

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u> | | | | c. LENGTH OF STAY IN 1b <u>4 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>(NMN)</u> Last <u>B arke</u> | | | | 4. DATE OF DEATH Month <u>September</u> Day <u>22</u> Year <u>1956</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2-I-83</u> | |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u> | | IF UNDER 24 HRS. Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u> | | 11. BIRTHPLACE (State or foreign country) <u>Russia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | | | | | | | |
| 13. FATHER'S NAME <u>Isadore Fader</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Eva ?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Hospital Records</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Acute hemorrhagic pancreatitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>587.0</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>5 days</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9-17, 1956</u> , to <u>9-22, 1956</u> , that I last saw the deceased alive on <u>9-21, 1956</u> , and that death occurred at <u>12:35 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | | | DATE SIGNED <u>9-22-56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>A. W. DANISIT</u> | | | | ADDRESS (Street, city or town, state) <u>Silver Spring Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>9/23/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Mt. Carmel</u> | | 22d. LOCATION (City, town, & county) (State) <u>Balto. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> | | | | 24a. REC'D BY REGISTRAR <u>[Signature]</u> | | | |
| 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | DATE <u>9/24/56</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9439

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09410
Reg. Dist. No. 216

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5411 Widloughby St</u> | | | | d. STREET ADDRESS <u>5411 Widloughby St</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Hobson</u> Last <u>Beauchamp</u> | | | | 4. DATE OF DEATH Month <u>Sept</u> Day <u>24</u> Year <u>1956</u> | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct 14 1898</u> | | | |
| 9. AGE (14 years last birthday) <u>57</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u> | | 11. BIRTHPLACE (State or foreign country) <u>Kansas</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | |
| 13. FATHER'S NAME <u>(UNKNOWN) BEAUCHAMP</u> | | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> | | 16. SOCIAL SECURITY NO. <u>WORLD WAR II 483-05-3174</u> | | 17. INFORMANT <u>THELMA BEAUCHAMP (WIFE) SAME AS # 2</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | | | | | |
| 20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> <u> </u> <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u> | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>SEPT. 27, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT. CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>CHEY CHASE FUNERAL HOME</u> | | | | ADDRESS <u>5103 WISCONSIN AVE</u> | | 24a. REC'D BY REGISTRAR <u> </u> | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u> </u> | | DATE <u>9/28/56</u> | | | |

DATE SIGNED

9-24-56

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
2. SEX: _____
3. AGE: _____
4. DATE OF BIRTH: _____
5. PLACE OF BIRTH: _____
6. OCCUPATION: _____
7. CAUSE OF DEATH: _____
8. MANNER OF DEATH: _____
9. SIGNATURE OF EXAMINER: _____
10. DATE OF EXAMINATION: _____

BUREAU V. S.

OCT 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9440

CERTIFICATE OF DEATH

09411

Reg. Dist. No. 214

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Mont.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9208 Long Branch Parkway</i> | | d. STREET ADDRESS <i>9208 Long Branch Parkway</i> | |
| 3. NAME OF DECEASED (Type or print) <i>James Floyd Beckham</i> | | 4. DATE OF DEATH <i>September 11, 1956</i> | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>5/5/95</i> |
| 9. AGE (In years last birthday) <i>61</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sign painter</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Thomas Beckham</i> | | 14. MOTHER'S MAIDEN NAME <i>Blanch Rhodes</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>James F. Beckham, Jr.</i> | | Address <i>son</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> <i>410X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Valvular (Mitral) Heart Disease 30 yrs</i> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <i>10 minutes</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Feb</i> , 19 <i>48</i> , to <i>Sept 11</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Sept 11</i> , 19 <i>56</i> , and that death occurred at <i>4 P</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>H B Orleans 9500 Calverville Rd Silver Spring Md</i> DATE SIGNED | | | |
| ACTUAL SIGNATURE <i>H B Orleans</i> | | M.D. <i>9500 Calverville Rd Silver Spring Md</i> | |
| PHYSICIAN'S NAME (Type) <i>H. B ORLEANS</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | 22b. DATE THEREOF <i>9/14/56</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cem.</i> | 22d. LOCATION (City, town, or county) (State) <i>Suitland, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co</i> | | 24a. REC'D BY REGISTRAR <i>9/17/56</i> | |
| ADDRESS <i>2901 14th St. N.W. Washington 9, D.C.</i> | | 24b. REGISTRAR'S SIGNATURE <i>Frances Potter</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9441 CERTIFICATE OF DEATH

09412
Reg. Dist. No. 216

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roanoke Rapids | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS 429 Charlotte Street | |
| 3. NAME OF DECEASED (Type or print) First Frederick Middle Laton Last Bell | | 4. DATE OF DEATH Month September Day 19 Year 56 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 12, 1943 |
| 9. AGE (In years last birthday) 13 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Julian Bell | | 14. MOTHER'S MAIDEN NAME Maurine Jenkins | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT The Medical Record | | Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute lymphocytic leukemia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 25, 1956 , to September 19, 1956 , that I last saw the deceased alive on September 19, 1956 , and that death occurred at 1:20 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Howard R. Engel | | DATE SIGNED 9/19/56 | |
| PHYSICIAN'S NAME (Type) Howard R. Engel, M. D. | | The Clinical Center National Institutes of Health Bethesda 14, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/21/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cedar Wood | | 22d. LOCATION (City, town, or county) (State) Roanoke Rapids, N. Carolina | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Beyhesda, Md. | | ADDRESS Robert A. Pumphrey-Beyhesda, Md. | |
| 24a. REC'D BY REGISTRAR DATE 9/22/56 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

BUREAU V. 8

SEP 25 1956

RECEIVED

Robert A. Murphy-Beynon, Jr.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9442 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09413
Reg. Dist. No. 216

| | | | | | | | | | |
|---|--|---|---|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> | | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3512 Turner Lane</u> | | | | d. STREET ADDRESS <u>3512 Turner Lane</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>LOUIS</u> First <u>PHILLIP</u> Middle <u>BEST</u> Last | | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>19 56</u> | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7-23-1901</u> | | | |
| 9. AGE (In years last birthday) <u>55</u> yrs. | | IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u> | | IF UNDER 24 HRS. Hours <u>10</u> Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mfg. Rep.</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Iowa</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | | |
| 13. FATHER'S NAME <u>Louis P. Best</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Clara Louise Krouse</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>262-09-7481</u> | | 17. INFORMANT Address <u>Stephen Best- Item # 2</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | <u>9/3/56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 22b. DATE THEREOF <u>9/5/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | | | 22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hauler's Sons</u> | | | | ADDRESS <u>1756 Pa. Ave., N.W. D.C.</u> | | 24a. REC'D BY REGISTRAR <u>8-11-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|----------------------|--|-------------------------|--|-----------------------|--|
| Name of Deceased | | Sex | | Age | |
| John Doe | | Male | | 45 | |
| Date of Death | | Place of Death | | Cause of Death | |
| Sept 12, 1956 | | Home | | Heart Disease | |
| Time of Death | | Manner of Death | | Signature of Examiner | |
| 10:00 AM | | Natural | | [Signature] | |
| Place of Burial | | Burial | | Date of Burial | |
| Crown Hill Cemetery | | Yes | | Sept 15, 1956 | |
| Name of Burial Place | | Name of Undertaker | | Name of Physician | |
| Crown Hill Cemetery | | John Doe | | John Doe | |
| Address of Deceased | | Address of Burial Place | | Address of Undertaker | |
| 123 Main St | | Crown Hill Cemetery | | John Doe | |
| City | | County | | State | |
| Baltimore | | Baltimore | | MD | |

100-10-1000

BUREAU V. S.

SEP 13 1956

RECEIVED

Operation 8/2/56

Order Bill Operatory

9443

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS - SAN. 3000 McCOMAS AVE</u> | | d. STREET ADDRESS <u>2300 40th St. N.W.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>DAISY</u> Middle <u>E</u> Last <u>BOTELER</u> | | 4. DATE OF DEATH Month <u>Sept</u> Day <u>7</u> Year <u>1966</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 6, 1879</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Frederick W. Burrows</u> | | 14. MOTHER'S MAIDEN NAME <u>Susana Bangs</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Gordon Boteler</u> | | Address <u>4921 47th St. N.W.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arterio-Sclerosis</u> DUE TO (c) <u>Thrombosing Arterio-Sclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>April 10, 1959</u> to <u>Sept 7, 1956</u> , that I last saw the deceased alive on <u>Aug - 17</u> , 19 <u>56</u> , and that death occurred at <u>4:45</u> P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | DATE SIGNED <u>3066 - [Signature]</u> | |
| PHYSICIAN'S NAME (Type) <u>[Signature]</u> | | ADDRESS (Street, city or town, state) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | 22b. DATE THEREOF <u>9/10/56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Suttland, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u> | | ADDRESS <u>2901 14th St. N.W.</u> | |
| 24a. REC'D BY REGISTRAR <u>7-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The form is partially filled with handwritten text and includes a large circular stamp in the center.

BUREAU V. S.

EP 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9444

CERTIFICATE OF DEATH

09415

Reg. Dist. No. 211

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus | | c. LENGTH OF STAY IN 1b Life | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus | | d. STREET ADDRESS Howard Chapel Drive | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Howard Chapel Drive | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Dr. George Milton Boyer | | 4. DATE OF DEATH Month Day Year Sept. 21 19 56 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 22, 1872 |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor | | 10b. KIND OF BUSINESS OR INDUSTRY Doctor | |
| 11. BIRTHPLACE (State or foreign country) Damascus, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Milton Boyer | | 14. MOTHER'S MAIDEN NAME Elizabeth Purdum | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or date of service) W.W. I | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Dr. M. McKendree Boyer, Damascus, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebro-Vascular Accident DUE TO (c) Arteriosclerosis, Generalized. INTERVAL BETWEEN ONSET AND DEATH 15 years 9 years years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign prostatic hypertrophy, Broncho-pneumonia, Decubitus ulcers | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 19 56 , to Sept. 21 , 19 56 , that I last saw the deceased alive on Sept. 20 , 19 56 , and that death occurred at 5:29 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Boyer Clinic, Damascus, Md. 9/24/56 | | | |
| ACTUAL SIGNATURE Gilcin F. Meadors, M.D. | | PHYSICIAN'S NAME (Type) Gilcin F. Meadors, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept. 24, 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY Boyer Mausoleum, Damascus, Md. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Chin L. Mobernath ADDRESS Damascus, Md. | | 24a. REC'D BY REGISTRAR DATE Sept 24/56 | |
| 24b. REGISTRAR'S SIGNATURE Della N. Burdette | | | |

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Journal of Management Education 30(6)

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Dr. J. McLaughlin Boyer, Gainesville, Fla.

BUREAU V. S.

SEP 26 1956

RECEIVED

9445

CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | |
|---|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Calvert | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN 1b 3 months | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESAPEAKE BEACH | | d. STREET ADDRESS MEARS AVENUE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,203 CARSON PLACE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ORDEN Middle BRAKE Last BRAKE | | 4. DATE OF DEATH Month SEPT. Day 11 Year 19 56 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/1/89 |
| 9. AGE (In years last birthday) yrs. 67 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ANALYST - FREIGHT RATE | | 10b. KIND OF BUSINESS OR INDUSTRY NAVY DEPT. | |
| 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME GEORGE W. BRAKE | | 14. MOTHER'S MAIDEN NAME IDA HAMNER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 274-01-6566 | |
| 17. INFORMANT Mrs. Louise Brake, 10,203 Carson Place Silver Spring, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic aneurysm (Ruptured) 022X DUE TO Lues Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lues DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10-12 yrs ? | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1947 to 11 Sept , 19 56 , that I last saw the deceased alive on 11 Sept , 19 56 , and that death occurred at 1:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William D. Aud M.D. 906 Calver Rd, Silver Spring, Md 9/12/56 | | | |
| ACTUAL SIGNATURE | | PHYSICIAN'S NAME (Type) WILLIAM D. AUD | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 9/14/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY | | 22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey | | ADDRESS SILVER SPRING, MD. | |
| 24a. REC'D BY REGISTRAR 9/12/56 | | 24b. REGISTRAR'S SIGNATURE Frances Lott | |

SEP 17 1956

BUREAU A.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9446

CERTIFICATE OF DEATH

Reg. Dist. No.

094177

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u> | |
| c. LENGTH OF STAY IN 1b <u>6 days</u> | | d. STREET ADDRESS <u>Brook Road</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Robin</u> Middle <u>Arlene</u> Last <u>Brooks</u> | | 4. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/31/56</u> |
| 9. AGE (In years last birthday) yrs. <u>6</u> | | 10. IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min. <u>6</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Allen Warfield Brooks</u> | | 14. MOTHER'S MAIDEN NAME <u>Robinette Viola Wilson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Hospital Record</u> | |
| 17. INFORMANT Address <u>(Mother)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0 Affections</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) _____ DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>8/31</u> , 19 <u>56</u> , to <u>9/6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/6</u> , 19 <u>56</u> , and that death occurred at <u>4:43 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | ADDRESS (Street, city or town, state) <u>Sandy Spring Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>A.D. BOUTLENT</u> | | DATE SIGNED <u>[Signature]</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>9/7/56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Sandy Spring Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R.L. Snowden</u> | | ADDRESS <u>Rockville, Maryland</u> | |
| 24a. REC'D BY REGISTRAR <u>9-10-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

2073266XVO

CERTIFICATE OF DEATH

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|--|--|---|--|--|--|
| NAME OF DECEASED [Handwritten: John A. Smith] | | SEX [Handwritten: Male] | | AGE [Handwritten: 45] | |
| DATE OF DEATH [Handwritten: September 13, 1956] | | PLACE OF DEATH [Handwritten: Baltimore, Maryland] | | COUNTY [Handwritten: Baltimore] | |
| TIME OF DEATH [Handwritten: 10:15 AM] | | PLACE OF BIRTH [Handwritten: Baltimore, Maryland] | | COUNTY OF BIRTH [Handwritten: Baltimore] | |
| OCCUPATION [Handwritten: Clerk] | | MARITAL STATUS [Handwritten: Married] | | CAUSE OF DEATH [Handwritten: Myocardial Infarction] | |
| MEDICAL HISTORY [Handwritten: Hypertension, Diabetes] | | PRESENT ILLNESS [Handwritten: Chest pain, shortness of breath] | | TIME OF ONSET [Handwritten: September 12, 1956] | |
| PHYSICIAN'S SIGNATURE [Handwritten: Dr. J. B. Jones] | | SIGNATURE OF DECEASED [Handwritten: John A. Smith] | | SIGNATURE OF WITNESS [Handwritten: Mary A. Smith] | |
| NAME OF PHYSICIAN [Handwritten: Dr. J. B. Jones] | | ADDRESS [Handwritten: 123 Main St, Baltimore, MD] | | CITY [Handwritten: Baltimore] | |
| STATE [Handwritten: Maryland] | | ZIP CODE [Handwritten: 21201] | | TELEPHONE [Handwritten: 555-1234] | |

RECEIVED
 SEP 13 1956
 MICHAEL V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9447

CERTIFICATE OF DEATH

09418

Reg. Dist. No. 215

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BETHESDA | | | | c. LENGTH OF STAY IN 1b 1 DAY | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | | | d. STREET ADDRESS 8570 2ND AVE. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, NMMC | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First FRANK Middle HARMON Last BURCH | | | | 4. DATE OF DEATH Month SEPTEMBER Day 26 Year 1956 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE CAUCASIAN | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH SEPTEMBER 21, 1886 | |
| 9. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYEE U.S. GOVERNMENT | | | | 10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE | | 11. BIRTHPLACE (State or foreign country) MISSISSIPPI | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME DAVID S. BURCH | | | | 14. MOTHER'S MAIDEN NAME ELLEN GREEN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES | | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1906 to 1922 UNK | | 17. INFORMANT RUBY R. BURCH 8570 2ND AVE. SILVER SPRING, MARYLAND | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 1 year | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Corebrovascular Accident | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 25 SEPTEMBER, 1956 , to 26 SEPTEMBER, 1956 , that I last saw the deceased alive on 26 SEPTEMBER, 1956 , and that death occurred at 4:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. NAVAL HOSPITAL, NMMC, BETHESDA, MD. DATE SIGNED 9/26/56 ACTUAL SIGNATURE R.G.W. WILLIAMS, JR. M.D. U.S. NAVAL HOSPITAL, NMMC, BETHESDA, MD. DATE SIGNED 9/26/56 PHYSICIAN'S NAME (Type) R.G.W. WILLIAMS, JR. CDR MC USN U.S. NAVAL HOSPITAL, NMMC, BETHESDA, MD. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 9-28-56 | | 22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL | | 22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY FUNERAL HOME | | | | ADDRESS 8434 GEORGIA AVE | | 24a. REC'D BY REGISTRAR 26 SEP 56 | |
| 24b. REGISTRAR'S SIGNATURE Mary E. Parselley | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG203 9-14-56 et

9448

CERTIFICATE OF DEATH

09419

Reg. Dist. No. 216

| | | | |
|---|---------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS 3302 Fayette Road. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Ada First L. Middle Burruss Last | | 4. DATE OF DEATH September 1st. 19 56 Month September Day 1st. Year 56 | |
| 5. SEX F. | 6. COLOR OR RACE W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 13th 1863 |
| 9. AGE (In years last birthday) 93 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Charles Phillips | | 14. MOTHER'S MAIDEN NAME Mary Toombs. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 10 (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Katherine B. Overstreet Address 3302 - Fayette Rd. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Cardiac Failure DUE TO (c) Adenocarcinoma of breast c Metastasis | | INTERVAL BETWEEN ONSET AND DEATH 20 min 30 min 4 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 1, 1955 to Sept 1, 1956 , that I last saw the deceased alive on 8/27, 1956 , and that death occurred at 8 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Frank Y. Jagers Jr. M.D. | | ADDRESS (Street, city or town, state) 5707 Westcousin Ave. DATE SIGNED 9/1/56 | |
| PHYSICIAN'S NAME (Type) FRANK Y. JAGGERS JR. | | Cherry Chase 15, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9-4-56 | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | 22d. LOCATION (City, town, or county) (State) Suitland Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Wm. Lees Sons Co ADDRESS 300 - 4th St. N.E. | | 24a. REC'D BY REGISTRAR 9-6-56 | 24b. REGISTRAR'S SIGNATURE Theresa M. Thompson |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09420

9449

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|--|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kentucky</u> b. COUNTY <u>Boyd</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashland</u> | |
| c. LENGTH OF STAY IN 1b <u>1 month</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | d. STREET ADDRESS <u>Rt. 2, Fed. Correctional Inst.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Esco Kingsley Callen</u> | | 4. DATE OF DEATH Month <u>Sept</u> Day <u>29</u> Year <u>1956</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 24, 1892</u> |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Fed. Institute Jefferson Co., Penn.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>William Callen</u> | | 14. MOTHER'S MAIDEN NAME <u>Lucy Riggs</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>W. Wayne Callen</u> | | Address <u>2707 Weisman Road, Silver Spring, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer Pancreas</u> DUE TO <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Lesions</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>5 weeks</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>8/16</u> , 19 <u>56</u> to <u>9/29</u> , 19 <u>56</u> that I last saw the deceased alive on <u>9/29/56</u> at <u>12:50 P.</u> M., and that death occurred at <u>1:50 P.</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John J. Curry</u> M.D. | | ADDRESS (Street, city or town, state) <u>11301 Georgia Ave., Silver Spring, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>JOHN J. CURRY, M.D.</u> | | DATE SIGNED <u>9/29/56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10-5-56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | ADDRESS <u>Bethesda, Maryland</u> | |
| 24a. REC'D BY REGISTRAR <u>10-2-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bea M. Thompson</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09422

9451

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | | |
| c. LENGTH OF STAY IN 1b May 31 - Sept 15 | | | | 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS - SANITARIUM | | | | d. STREET ADDRESS 2220 20th St. N.W. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Florence Middle Carpenter Last | | | | 4. DATE OF DEATH Month Sept Day 15 Year 1956 | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1/23/1881 | |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary, American Medical Research | | | | 10b. KIND OF BUSINESS OR INDUSTRY Mass. | | | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Carpenter | | | | 14. MOTHER'S MAIDEN NAME Vilas | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Address Rachel Mary Jane Shapleigh, sister-in-law | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 months |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May , 19 56 , to Sept , 19 56 , that I last saw the deceased alive on 9/14 , 19 56 , and that death occurred at 11:40 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Irving W. Winik M.D. | | | | ADDRESS (Street, city or town, state) 3900 McKinley St. N.W., Wash, D.C. DATE SIGNED 9/15/56 | | | |
| PHYSICIAN'S NAME (Type) Irving W. Winik | | | | | | | |
| 22a. TOTAL CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF 9/15/56 | | 22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory | | 22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W., ADDRESS Wash, DC | | | | 24a. REC'D BY REGISTRAR 9-17-56 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

CERTIFICATE OF DEATH

| | | | | | |
|---------------------------------------|--|--------------------------------------|--|-------------------------------------|--|
| NAME OF DECEASED [Illegible] | | SEX [Illegible] | | AGE [Illegible] | |
| DATE OF DEATH [Illegible] | | PLACE OF DEATH [Illegible] | | CITY [Illegible] | |
| COUNTY [Illegible] | | STATE [Illegible] | | ZIP CODE [Illegible] | |
| OCCUPATION [Illegible] | | CAUSE OF DEATH [Illegible] | | MANNER OF DEATH [Illegible] | |
| MEDICAL HISTORY [Illegible] | | PRESENT ILLNESS [Illegible] | | TREATMENT [Illegible] | |
| SIGNATURE OF PHYSICIAN [Illegible] | | SIGNATURE OF DECEASED [Illegible] | | SIGNATURE OF WITNESS [Illegible] | |
| DATE [Illegible] | | TIME [Illegible] | | PLACE [Illegible] | |

RECEIVED
 SEP 19 1956
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9452

CERTIFICATE OF DEATH

Reg. Dist. No. 09423 16

| | | | |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY - | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| d. NAME OF HOSPITAL OR INSTITUTION The Clinical Center National Institutes of Health | | d. STREET ADDRESS 4801 Texas Ave., N.W., Apt. 203 | |
| 3. NAME OF DECEASED (Type or print) First Helen Middle Rebecca Last Carter | | 4. DATE OF DEATH Month September Day 30 Year 1956 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7 March 1905 |
| 9. AGE (In years last birthday) 51 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Char Woman | | 10b. KIND OF BUSINESS OR INDUSTRY Government | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Isaac Dyson | | 14. MOTHER'S MAIDEN NAME Susie Woodland | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. not available | |
| 17. INFORMANT The Medical Record, Clinical Center | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: adenocarcinoma of cervix. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) rupture of the uterus. (c) peritonitis. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 1 year 6 days 6 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 13 September 1956 to 30 September 1956 , that I last saw the deceased alive on 30 September 1956 , and that death occurred at 8:20 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE David G. Nathan, M.D. | | ADDRESS (Street, city or town, state) Clinical Center, National Institutes of Health, Bethesda 14, Md. | |
| PHYSICIAN'S NAME (Type) David G. Nathan, M. D. | | DATE SIGNED 10/1/56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 10/4/56 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | 22d. LOCATION (City, town, or county) (State) Washington, D. C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert G. McGuire | | ADDRESS 1820 9th St., N.W. Washington, D.C. | |
| 24a. REC'D BY REGISTRAR DATE 3 1956 | | 24b. REGISTRAR'S SIGNATURE Bessie Thompson | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|------------------------|--|-------------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | STATE | | COUNTRY | |
| JAMES V. BUREAU | | M | | 38 | | 1918 | | BALTIMORE | | MD | | MD | | USA | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | RACE | | COLOR | | HAIR | | EYES | |
| Clerical | | High School | | Married | | Roman Catholic | | White | | White | | Brown | | Blue | |
| CAUSE OF DEATH | | IMMEDIATE | | INTERMEDIATE | | FINAL | | MANNER OF DEATH | | PLACE OF DEATH | | CITY | | STATE | |
| Myocardial Infarction | | Coronary Artery Disease | | Hypertension | | Atherosclerosis | | Natural | | Home | | BALTIMORE | | MD | |
| DATE OF DEATH | | TIME OF DEATH | | HOUR | | MINUTE | | DAY | | MONTH | | YEAR | | CITY | |
| October 3, 1956 | | 10:15 AM | | 10 | | 15 | | October | | 1956 | | BALTIMORE | | MD | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

RECEIVED
OCT 3 1956
BUREAU V. B.

9453

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|--|--|----------------------------------|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. LENGTH OF STAY IN 1b <u>2 mo. 9 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | | | d. STREET ADDRESS <u>601 Anderson Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>S</u> Last <u>CARTWRIGHT</u> | | | | 4. DATE OF DEATH Month <u>9</u> Day <u>23</u> Year <u>1956</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2-18-91</u> | |
| 9. AGE (In years last birthday) <u>65</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. | | 10. MONTHS <u>6</u> DAYS <u>5</u> HOURS <u></u> MIN. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Iron Worker</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> | | 11. BIRTHPLACE (State or foreign country) <u>Illinois</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | | | 16. SOCIAL SECURITY NO. <u>577-28-8773</u> | | 17. INFORMANT <u>Mabel Cartwright - wife</u> Address <u>601 Anderson Ave. Rockville, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis</u> <u>191X</u> DUE TO <u>aggravated carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>carcinomatosis</u> DUE TO <u>industrial injury 1950</u> (c) <u></u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m. <u></u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>1950</u> , 19 <u></u> , to <u>date</u> , 19 <u></u> , that I last saw the deceased alive on <u>Sept 22</u> , 19 <u>56</u> , and that death occurred at <u>3:20 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>John O. Robben</u> M.D. <u>7930 Georgia Silver Spring, Md.</u> | | | | DATE SIGNED <u>9-24-56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>John O. Robben M.D.</u> | | | | ADDRESS <u>7930 Georgia Ave. Silver Sp. Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9-26-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumfrey</u> ADDRESS <u>Bethesda Md</u> | | | | 24a. REC'D BY REGISTRAR <u>9-24-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9454

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN lb 58 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Irma Middle Niedomanski Last Catlett | | 4. DATE OF DEATH Month September Day 8 Year 19 56 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 6, 1906 |
| 9. AGE (In years last birthday) yrs. 50 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Office Work | |
| 11. BIRTHPLACE (State or foreign country) Penna. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John F. Niedomanski | | 14. MOTHER'S MAIDEN NAME Mary Haynie | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 577-09-0124 | |
| 17. INFORMANT The Medical Record | | address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral metastases 170 X DUE TO Carcinoma of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 12 , 19 56 , to September 8 , 19 56 , that I last saw the deceased alive on September 8 , 19 56 , and that death occurred at 8:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE W. J. Pieper | | M.D. The Clinical Center | |
| PHYSICIAN'S NAME (Type) W. J. Pieper, M. D. | | National Institutes of Health | |
| Bethesda 14, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 11 Sept 1956 | 22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN | 22d. LOCATION (City, town, or county) (State) COLMAR MANOR, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Nalleys Funeral Home, Mt. Rainier, Md. | | 24a. REC'D BY REGISTRAR DATE 8-10-56 | |
| 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO.

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| DECEASED NAME LAST FIRST MIDDLE JAMES EARL RAY | | SEX Male | | RACE White | | DATE OF BIRTH May 19, 1928 | | PLACE OF BIRTH Jackson, Mississippi | | DATE OF DEATH April 4, 1968 | | PLACE OF DEATH Memphis, Tennessee | | TIME OF DEATH 9:01 AM | | CAUSE OF DEATH Gunshot wound | | MANNER OF DEATH Homicide | | MEDICAL EXAMINER JAMES EARL RAY | | SIGNATURE OF MEDICAL EXAMINER JAMES EARL RAY | | SIGNATURE OF DECEASED JAMES EARL RAY | | SIGNATURE OF NEXT OF KIN JAMES EARL RAY | | SIGNATURE OF WITNESS JAMES EARL RAY | | SIGNATURE OF CLERK JAMES EARL RAY | | SIGNATURE OF REGISTRAR JAMES EARL RAY | | SIGNATURE OF JUDGE JAMES EARL RAY | | SIGNATURE OF SHERIFF JAMES EARL RAY | | SIGNATURE OF CORONER JAMES EARL RAY | | SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY | | SIGNATURE OF COUNTY CLERK JAMES EARL RAY | | SIGNATURE OF CITY CLERK JAMES EARL RAY | | SIGNATURE OF VICE MAYOR JAMES EARL RAY | | SIGNATURE OF MAYOR JAMES EARL RAY | |
| DATE OF BIRTH May 19, 1928 | | PLACE OF BIRTH Jackson, Mississippi | | DATE OF DEATH April 4, 1968 | | PLACE OF DEATH Memphis, Tennessee | | TIME OF DEATH 9:01 AM | | CAUSE OF DEATH Gunshot wound | | MANNER OF DEATH Homicide | | MEDICAL EXAMINER JAMES EARL RAY | | SIGNATURE OF MEDICAL EXAMINER JAMES EARL RAY | | SIGNATURE OF DECEASED JAMES EARL RAY | | SIGNATURE OF NEXT OF KIN JAMES EARL RAY | | SIGNATURE OF WITNESS JAMES EARL RAY | | SIGNATURE OF CLERK JAMES EARL RAY | | SIGNATURE OF REGISTRAR JAMES EARL RAY | | SIGNATURE OF JUDGE JAMES EARL RAY | | SIGNATURE OF SHERIFF JAMES EARL RAY | | SIGNATURE OF CORONER JAMES EARL RAY | | SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY | | SIGNATURE OF COUNTY CLERK JAMES EARL RAY | | SIGNATURE OF CITY CLERK JAMES EARL RAY | | SIGNATURE OF VICE MAYOR JAMES EARL RAY | | SIGNATURE OF MAYOR JAMES EARL RAY | | | | | | | |

BUREAU V. S.

SEP 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09426

9455

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|--|-------------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE VIRGINIA b. COUNTY ALEXANDRIA | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL) | | | | c. LENGTH OF STAY IN 1b 2 Hr. 35 MIN. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALEXANDRIA | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL BETHESDA, MARYLAND | | | | d. STREET ADDRESS 4517 TANEY STREET | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last CHAMBERS | | | | 4. DATE OF DEATH Month SEPTEMBER Day 26 Year 19 56 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 26 September 1956 | | 9. AGE (In years lost birthday) yrs. 2 | IF UNDER 1 YEAR Months 2 Days 18 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME GERALD PHILLIP CHAMBERS | | | | 14. MOTHER'S MAIDEN NAME RUBY HULDA INGRAM | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Address (FATHER) GERALD PHILLIP CHAMBERS (SAME AS #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ERYTHROBLASTOSIS FETALIS 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2HR 35 MIN. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 26 Sept. , 19 56 , to 26 Sept. , 19 56 , that I last saw the deceased alive on 26 Sept. , 19 56 , and that death occurred at 8:17 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ | | | | | | | |
| ACTUAL SIGNATURE Daniel Shuptar | | | | M.D. U.S. Naval Hospital, Bethesda, Md. 9-28-56 | | | |
| PHYSICIAN'S NAME (Type) Daniel Shuptar, LT. MC USN | | | | U.S. Naval Hospital, Bethesda, Md. 9-28-56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-30-56 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey | | | | ADDRESS Bethesda, Md. | | 24a. REC'D BY REGISTRAR 9-28-56 24b. REGISTRAR'S SIGNATURE Marjorie L. Parrelly | |

2051242 XV5

BUREAU V. S.

1956 OCT 1

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09427
9456
CERTIFICATE OF DEATH

Reg. Dist. No. *216*

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | | | | c. LENGTH OF STAY IN 1b <i>6 days + 20 hrs</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i> | | | | d. STREET ADDRESS <i>4626 Woodfield Rd.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>May</i> Middle <i>Ann</i> Last <i>Loon</i> | | | | 4. DATE OF DEATH Month <i>Sept</i> Day <i>3</i> Year <i>1956</i> | | | |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>White</i> | | 7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>June 21 1877</i> | |
| 9. AGE (In years last birthday) <i>79</i> yrs. | | IF UNDER 1 YEAR Months <i>2</i> Days <i>12</i> | | IF UNDER 24 HRS. Hours <i>—</i> Min. <i>—</i> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i> | | 11. BIRTHPLACE (State or foreign country) <i>Scotland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | | | | | | |
| 13. FATHER'S NAME <i>James Williamson</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Agnes Teenie</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | | 17. INFORMANT <i>Mrs Agnes Hutchison</i> | | Address <i>4626 Woodfield Rd Bethesda, Md</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO <i>260x</i> (b) <i>Arteriosclerosis and Diabetes</i> DUE TO <i>Gangrene left 4th toe</i> (c) <i>—</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Gangrene left 4th toe</i> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a. g. <i>19</i> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Aug 28</i> , 1956, to <i>Sept 3</i> , 1956, that I last saw the deceased alive on <i>Sept 3</i> , 1956, and that death occurred at <i>7:15</i> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>8641 Colesville Rd.</i> DATE SIGNED <i>—</i> | | | | | | | |
| ACTUAL SIGNATURE <i>Leon Gerber</i> | | | | M.D. <i>8641 Colesville Rd.</i> | | | |
| PHYSICIAN'S NAME (Type) <i>Leon Gerber</i> | | | | Silver Spring, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>9-6-56</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln</i> | | 22d. LOCATION (City, town, or county) (State) <i>Prince Georges Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i> | | | | ADDRESS <i>Bethesda, Md.</i> | | 24a. REC'D BY REGISTRAR <i>9-8-56</i> 24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18
 CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------------|--|-----------------------|--|----------------------|--|-----------------------|--|----------------------|--|-----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| MARRIED | | SINGLE | | WIDOWED | | DIVORCED | | DATE OF DEATH | | PLACE OF DEATH | |
| CAUSE OF DEATH | | MANNER OF DEATH | | DURATION OF ILLNESS | | PREVAILING DISEASE | | DATE OF ONSET | | DATE OF LAST ILLNESS | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF DECEASED | |

BUREAU V. S.

SEP 10 1956

RECEIVED

9412

CERTIFICATE OF DEATH

Reg. Dist. No.

223

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK | | | | c. LENGTH OF STAY IN 1b 3 yrs. | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | | | 17 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 708 PHILADELPHIA AVENUE | | | | d. STREET ADDRESS 108 GRANT AVENUE | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last CRONE | | | | 4. DATE OF DEATH Month Sept Day 13 Year 1956 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 24, 1875 | 9. AGE (In years last birthday) 81 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SURVEYOR - retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY D.C. GOV'T. | | 11. BIRTHPLACE (State or foreign country) MIDDLETOWN, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME JOSEPH CRONE | | | | 14. MOTHER'S MAIDEN NAME ANN RUTZAHN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Mrs. Nina C. Wright, 108 Grant Ave. Takoma Park, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) benign atherosclerosis DUE TO (c) 10 years | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 11 Sept , 19 56 , to 13 Sept , 19 56 , that I last saw the deceased alive on 12 Sept , 19 56 , and that death occurred at 6:47 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Y. B. Queen | | | | ADDRESS (Street, city or town, state) 7112 Willow Ave | | | |
| PHYSICIAN'S NAME (Type) A. B. QUEEN | | | | DATE SIGNED 13 Sept 1956 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 9/17/56 | | 22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. MEM. CEMETERY | | 22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey | | | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR DATE 9/17/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE J. H. R. D. D. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND—Baltimore, 10

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF FUNERAL HOME

NAME OF UNDERTAKER

NAME OF COFFIN

NAME OF CASK

NAME OF CASK

NAME OF CASK

NAME OF CASK

NAME OF CASK

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BUREAU V. 8

SEP 18 1956

RECEIVED

9457

CERTIFICATE OF DEATH

Reg. Dist. No.

214

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium | | d. STREET ADDRESS 9030 49th Avenue | |
| 3. NAME OF DECEASED (Type or print) First Merton Middle Gedney Last Currey | | 4. DATE OF DEATH Month September Day 30 Year 1956 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept 25, 1877 |
| 9. AGE (In years and birthday) 79 | | 10. IF UNDER 1 YEAR Months 16 Days 14 Hours 2 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Traveling | |
| 11. BIRTHPLACE (State or foreign country) Michigan | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Alford Currey | | 14. MOTHER'S MAIDEN NAME Eleanor Doyle | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT no | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO Arteriosclerosis with mitral stenosis and regurgitation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO over 20 years | | | INTERVAL BETWEEN ONSET AND DEATH 21 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Sept. 26, 1956 to Sept. 20, 1956 , that I last saw the deceased alive on Sept. 29, 1956 , and that death occurred at 8 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Katharine A. Chapman M.D. | | DATE SIGNED Sept. 30, 1956 | |
| PHYSICIAN'S NAME (Type) Katharine Chapman | | ADDRESS (Street, city or town, State) 3924 Baltimore St. Kensington, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 10/3/56 | 22c. NAME OF CEMETERY OR George Washington | 22d. LOCATION (City, town, or county) (State) Hyattsville, Maryland. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Francis Barch's Sons | | 24a. REC'D BY REGISTRAR Hyattsville, Md. | 24b. REGISTRAR'S SIGNATURE Francis Barch's Sons |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 3 1956

RECEIVED

9450

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | | | d. STREET ADDRESS <u>7 PARK AVENUE</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Roger</u> - <u>Carlisle</u> | | | | 4. DATE OF DEATH Month Day Year <u>Sept.</u> <u>8</u> 19 <u>56</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9-27-90</u> | |
| 9. AGE (In years last birthday) <u>65</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRAKEMAN</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>B&O R.R.</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>William M. Carlisle</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mariam Walker</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>Mar 1 -</u> | | | | 16. SOCIAL SECURITY NO. <u>108 N. Frederick Ave.</u> | | | |
| 17. INFORMANT Address <u>Gaithersburg</u> | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic Carcinoma</u> DUE TO <u>in left side</u> (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I attended the deceased from <u>Oct 25, 1955</u> to <u>Sep 8, 1956</u> , that I last saw the deceased alive on <u>Sep 7, 1956</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Luciano I. Ledl</u> M.D. <u>108 N. Frederick Ave.</u> | | | | DATE SIGNED _____ | | | |
| PHYSICIAN'S NAME (Type) <u>Luciano I. Ledl</u> <u>Gaithersburg Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9-11-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u> | | 22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Hartman, Gaithersburg Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>9-11-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|--------------------------------------|--|
| NAME OF DECEASED [Faint text] | | DATE OF DEATH [Faint text] | |
| PLACE OF DEATH [Faint text] | | CITY OR TOWN [Faint text] | |
| COUNTY [Faint text] | | STATE [Faint text] | |
| AGE [Faint text] | | SEX [Faint text] | |
| MARRIED [Faint text] | | OCCUPATION [Faint text] | |
| EDUCATION [Faint text] | | RELIGION [Faint text] | |
| CAUSE OF DEATH [Faint text] | | MANNER OF DEATH [Faint text] | |
| DATE OF BURIAL [Faint text] | | PLACE OF BURIAL [Faint text] | |
| SIGNATURE OF DECEASED [Faint text] | | SIGNATURE OF WITNESS [Faint text] | |
| SIGNATURE OF PHYSICIAN [Faint text] | | SIGNATURE OF CORONER [Faint text] | |
| SIGNATURE OF JUDGE [Faint text] | | SIGNATURE OF CLERK [Faint text] | |

BUREAU V. S.

SEP 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9458

CERTIFICATE OF DEATH

Reg. Dist. No. 215

09430

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 17 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland | | | | e. STREET ADDRESS RFD #2, Box 544 | | | |
| 3. NAME OF DECEASED (Type or print) First Baby Boy Middle DARNEY Last DARNEY | | | | 4. DATE OF DEATH Month September Day 6 Year 19 56 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 17 Aug. 1956 | |
| 9. AGE (In years lost birthday) yrs. 16 | | IF UNDER 1 YEAR Months 20 Days 16 Hours 2 Min. | | IF UNDER 24 HRS. Hours 16 Min. 2 | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME Edward DARNEY | | | | 14. MOTHER'S MAIDEN NAME Glades FOWLER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - | | | | 16. SOCIAL SECURITY NO. None | | | |
| 17. INFORMANT (Father) Edward Darney (Same as #2) | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 768.5 IMMEDIATE CAUSE (a) PREMATURITY DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) IMMATURITY DUE TO (c) FULMINATING INFECTION INTERVAL BETWEEN ONSET AND DEATH 20 Days 20 Days | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from 20 Aug. , 19 56 , to 6 SEPT , 19 56 , that I last saw the deceased alive on 6 SEPT. , 19 56 , and that death occurred at 5:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-10-56 | | | | | | | |
| ACTUAL SIGNATURE Daniel Shuptar | | | | M.D. U.S. Naval Hospital, Bethesda, Md. | | | |
| PHYSICIAN'S NAME (Type) Daniel Shuptar, LT, MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 9-12-56 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | |
| 22d. LOCATION (City, town, or county) Arlington, Virginia | | | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey | | | | ADDRESS Federal Home, 7557 Wisconsin Ave. | | 24a. REC'D BY REGISTRAR 9-9-56 | |
| 24b. REGISTRAR'S SIGNATURE May E. Parrelly | | | | | | | |

2050362 X V 2

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

| BALTIMORE, 18 | | | | | | | | | | 09431/4 | | | |
|--|--|--|---|---|---|--|--|---|---|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>107 Croyden Ct.</u> | | | | | d. STREET ADDRESS <u>107 Croyden Ct.</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Kimberly Jean Dodge</u> | | | | | 4. DATE OF DEATH Month Day Year <u>9/16/56</u> <u>19</u> | | | | | | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7/27/56</u> | | 9. AGE (In years last birthday) <u>0</u> yrs. | | IF UNDER 1 YEAR Months Days <u>1</u> <u>19</u> | | IF UNDER 24 HRS. Hours Min. <u></u> <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Herbert W. Dodge</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Viola J. Love</u> | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT Address <u>Father Same as Item 2</u> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>500X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>tracheo-bronchitis</u> DUE TO (c) <u></u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bed</u> | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | | 22b. DATE THEREOF <u>9/19/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u> | | | 22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey,</u> | | | | | ADDRESS <u>SILVER SPRING, MD.</u> | | 24a. REC'D BY REGISTRAR <u>9/20/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles Teller</u> | | | | |

2075191XV7

MISSOURI STATE DEPARTMENT OF HEALTH - BATHING IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|-----------------------|--|------------------|--|------------------------|--|----------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF DEATH | |
| PLACE OF DEATH | | CITY | | COUNTY | | STATE | |
| OCCUPATION | | EDUCATION | | RELIGION | | MARRIAGE | |
| CAUSE OF DEATH | | MANNER OF DEATH | | MEDICAL HISTORY | | POST-MORTEM | |
| SIGNATURE OF EXAMINER | | DATE | | TIME | | PLACE | |
| FINGERPRINTS | | PHOTOGRAPH | | X-RAY | | LABORATORY | |
| TESTS | | TREATMENT | | PROGNOSIS | | REMARKS | |
| FAMILY HISTORY | | SOCIAL HISTORY | | PSYCHOLOGICAL HISTORY | | PATHOLOGICAL HISTORY | |
| PREVIOUS ILLNESSES | | SURGICAL HISTORY | | MEDICATIONS | | VACCINATIONS | |
| ALLERGIES | | TOBACCO USE | | ALCOHOL USE | | DRUG USE | |
| DIET | | EXERCISE | | STRESS | | ENVIRONMENT | |
| FAMILY RELATIONS | | SOCIAL RELATIONS | | OCCUPATIONAL RELATIONS | | LEGAL RELATIONS | |
| FINANCIAL STATUS | | Housing | | Utilities | | Insurance | |
| Other | | Other | | Other | | Other | |

RECEIVED
SEP 24 1956
BUREAU V. S.

9460

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | |
| c. LENGTH OF STAY IN 1b 6 days | | | | d. STREET ADDRESS 7505 Ben Avon Road | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Margaret Middle Dooley Last Dooley | | | | 4. DATE OF DEATH Month Sept Day 17 Year 1956 | | | |
| 5. SEX F | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4/30/79 | |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. | | IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY — | | | |
| 11. BIRTHPLACE (State or foreign country) Connecticut | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME John F. Maloney | | | | 14. MOTHER'S MAIDEN NAME Margaret Dooley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0 | | | | 16. SOCIAL SECURITY NO. Maguerite de la Croix Bethesda | | | |
| 17. INFORMANT Maguerite de la Croix | | | | Address 7505 Ben Avon Rd. Bethesda | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422X Congestive Heart Failure. Hypertensive DUE TO (b) Uremia DUE TO (c) Arterio Sclerosis - Cardio Vascular disease INTERVAL BETWEEN ONSET AND DEATH 6 days 10 days 20 yr. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital Fusion and displacement of Kidneys | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 7 Aug , 19 53 , to 17 Sept , 19 56 , that I last saw the deceased alive on 17 Sept , 19 56 , and that death occurred at 9:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7936 Georgetown Rd. Bethesda 14 Md. DATE SIGNED 9/22/56 | | | | | | | |
| ACTUAL SIGNATURE John S. Ball | | | | M.D. 7936 Georgetown Rd. Bethesda 14 Md. | | | |
| PHYSICIAN'S NAME (Type) Robert A. Pumphrey-Bethesda, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 9/19/56 | | | | 22b. DATE THEREOF 9/19/56 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Thomas | | | | 22d. LOCATION (City, town, or county) (State) Springfield, Mass. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR Beane M. Thompson | | | |
| 24b. REGISTRAR'S SIGNATURE | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 25 1956

BUREAU V. 3

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9461 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09433

Reg. Dist. No. 216

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8902 Melwood Road | | | | d. STREET ADDRESS 8902 Melwood Road | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last JOSEPHINE A. DOYLE | | | | 4. DATE OF DEATH Month Day Year September 25, 19 56 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 4, 1910 | | 9. AGE (In years last birthday) 45 yrs. | IF UNDER 1 YEAR Months Days 10 21 | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Malt., Md. | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Joseph Daniels | | | | 14. MOTHER'S MAIDEN NAME Anna ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address John J. Doyle- Item # 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 9/25/56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/28/56 | | 22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | 22d. LOCATION (City, town, or county) (State) Montgomery Co., Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR DATE 9-26-56 | | 24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. No burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
 0881 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-----------------------|--|------------------------|--|
| Name of Deceased | | Joseph Daniels | |
| Sex | | Male | |
| Race | | White | |
| Date of Birth | | 1901 | |
| Place of Birth | | Maryland | |
| Residence | | 8802 Melwood Road | |
| Cause of Death | | Heart Disease | |
| Date of Death | | September 23, 1956 | |
| Time of Death | | 10:30 | |
| Signature of Examiner | | John J. Doyle - Item 1 | |

| | | | |
|------------------------|--|------------------------|--|
| Name of Physician | | Joseph Daniels | |
| Address | | 8802 Melwood Road | |
| City | | Baltimore | |
| State | | Maryland | |
| Date of Examination | | September 23, 1956 | |
| Signature of Physician | | John J. Doyle - Item 2 | |

BUREAU V. 2

OCT 1 1956

RECEIVED

| | | | |
|---------------------------|--|------------------------|--|
| Name of Burial Place | | Catholics - Baltimore | |
| Address | | 8802 Melwood Road | |
| City | | Baltimore | |
| State | | Maryland | |
| Date of Burial | | September 23, 1956 | |
| Signature of Burial Place | | John J. Doyle - Item 3 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 9462 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

09434
214
Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, MD.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL HALL SANITARIUM.</u> | | d. STREET ADDRESS <u>9510 Ocala St.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>MAY</u> Last <u>DUFFY</u> | | 4. DATE OF DEATH Month <u>SEPT.</u> Day <u>14</u> Year <u>1956</u> | |
| 5. SEX <u>FE</u> | 6. COLOR OR RACE <u>WH.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-1-77</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.S.W. - OWN HOME</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>CANADA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>WILLIAM BOLER.</u> | | 14. MOTHER'S MAIDEN NAME <u>ELLEN BROGAN.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Records.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic-hypertensive heart dis.</u> DUE TO (c) <u>—</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>6 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>—</u> <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Sept 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 14</u> , 19 <u>56</u> , and that death occurred at <u>12:45</u> A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>William F. Simpson, Jr.</u> M.D. | | ADDRESS (Street, city or town, state) <u>6216 N.H. Ave N.E.</u> DATE SIGNED <u>9/14/56</u> | |
| PHYSICIAN'S NAME (Type) <u>William F Simpson Jr.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>9/17/56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u> | 22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey,</u> ADDRESS <u>SILVER SPRING, MD.</u> | | 24a. REC'D BY REGISTRAR <u>7/7/56</u> | 24b. REGISTRAR'S SIGNATURE <u>Frances Toller</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9463

CERTIFICATE OF DEATH

09435

Reg. Dist. No. 216

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | d. STREET ADDRESS <u>Great Falls Road</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Beatrice</u> Last <u>Dunn</u> | | 4. DATE OF DEATH Month <u>9</u> - Day <u>26</u> Year <u>1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-26-04</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>52</u> yrs. |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Robert Cook</u> | | 14. MOTHER'S MAIDEN NAME <u>Alice Broadrick</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>44-49 T STREET NW WASH. D.C.</u> | |
| 17. INFORMANT <u>James P. Dunn - Son</u> Address <u>449 T STREET NW WASH. D.C.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>Unknown</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>9/24/56</u> , to <u>9/26/56</u> , that I last saw the deceased alive on <u>9/26/56</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Stephen R. Jones</u> M.D. | | ADDRESS (Street, city or town, state) <u>Rockville Md</u> DATE SIGNED <u>9/28/56</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>9/29/56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u> | 22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surden</u> ADDRESS <u>Rockville, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DATE 10-2-56</u> | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> |

CERTIFICATE OF DEATH

1956

Page 1 of 1

| | | | | | |
|---|--|--|--|-------------------------------------|--|
| 1. NAME OF DECEASED <i>John F. Smith</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>65</i> | |
| 4. RACE <i>White</i> | | 5. BIRTH DATE <i>1911</i> | | 6. BIRTH PLACE <i>MD</i> | |
| 7. DECEASED DATE <i>1956</i> | | 8. DECEASED PLACE <i>MD</i> | | 9. DECEASED TIME <i>10:00 AM</i> | |
| 10. DECEASED CAUSE <i>Heart Disease</i> | | 11. DECEASED DISEASE <i>Coronary Artery Disease</i> | | 12. DECEASED ORGAN <i>Heart</i> | |
| 13. DECEASED ORGAN <i>Heart</i> | | 14. DECEASED ORGAN <i>Heart</i> | | 15. DECEASED ORGAN <i>Heart</i> | |
| 16. DECEASED ORGAN <i>Heart</i> | | 17. DECEASED ORGAN <i>Heart</i> | | 18. DECEASED ORGAN <i>Heart</i> | |
| 19. DECEASED ORGAN <i>Heart</i> | | 20. DECEASED ORGAN <i>Heart</i> | | 21. DECEASED ORGAN <i>Heart</i> | |
| 22. DECEASED ORGAN <i>Heart</i> | | 23. DECEASED ORGAN <i>Heart</i> | | 24. DECEASED ORGAN <i>Heart</i> | |
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| 34. DECEASED ORGAN <i>Heart</i> | | 35. DECEASED ORGAN <i>Heart</i> | | 36. DECEASED ORGAN <i>Heart</i> | |
| 37. DECEASED ORGAN <i>Heart</i> | | 38. DECEASED ORGAN <i>Heart</i> | | 39. DECEASED ORGAN <i>Heart</i> | |
| 40. DECEASED ORGAN <i>Heart</i> | | 41. DECEASED ORGAN <i>Heart</i> | | 42. DECEASED ORGAN <i>Heart</i> | |
| 43. DECEASED ORGAN <i>Heart</i> | | 44. DECEASED ORGAN <i>Heart</i> | | 45. DECEASED ORGAN <i>Heart</i> | |
| 46. DECEASED ORGAN <i>Heart</i> | | 47. DECEASED ORGAN <i>Heart</i> | | 48. DECEASED ORGAN <i>Heart</i> | |
| 49. DECEASED ORGAN <i>Heart</i> | | 50. DECEASED ORGAN <i>Heart</i> | | 51. DECEASED ORGAN <i>Heart</i> | |
| 52. DECEASED ORGAN <i>Heart</i> | | 53. DECEASED ORGAN <i>Heart</i> | | 54. DECEASED ORGAN <i>Heart</i> | |
| 55. DECEASED ORGAN <i>Heart</i> | | 56. DECEASED ORGAN <i>Heart</i> | | 57. DECEASED ORGAN <i>Heart</i> | |
| 58. DECEASED ORGAN <i>Heart</i> | | 59. DECEASED ORGAN <i>Heart</i> | | 60. DECEASED ORGAN <i>Heart</i> | |
| 61. DECEASED ORGAN <i>Heart</i> | | 62. DECEASED ORGAN <i>Heart</i> | | 63. DECEASED ORGAN <i>Heart</i> | |
| 64. DECEASED ORGAN <i>Heart</i> | | 65. DECEASED ORGAN <i>Heart</i> | | 66. DECEASED ORGAN <i>Heart</i> | |
| 67. DECEASED ORGAN <i>Heart</i> | | 68. DECEASED ORGAN <i>Heart</i> | | 69. DECEASED ORGAN <i>Heart</i> | |
| 70. DECEASED ORGAN <i>Heart</i> | | 71. DECEASED ORGAN <i>Heart</i> | | 72. DECEASED ORGAN <i>Heart</i> | |
| 73. DECEASED ORGAN <i>Heart</i> | | 74. DECEASED ORGAN <i>Heart</i> | | 75. DECEASED ORGAN <i>Heart</i> | |
| 76. DECEASED ORGAN <i>Heart</i> | | 77. DECEASED ORGAN <i>Heart</i> | | 78. DECEASED ORGAN <i>Heart</i> | |
| 79. DECEASED ORGAN <i>Heart</i> | | 80. DECEASED ORGAN <i>Heart</i> | | 81. DECEASED ORGAN <i>Heart</i> | |
| 82. DECEASED ORGAN <i>Heart</i> | | 83. DECEASED ORGAN <i>Heart</i> | | 84. DECEASED ORGAN <i>Heart</i> | |
| 85. DECEASED ORGAN <i>Heart</i> | | 86. DECEASED ORGAN <i>Heart</i> | | 87. DECEASED ORGAN <i>Heart</i> | |
| 88. DECEASED ORGAN <i>Heart</i> | | 89. DECEASED ORGAN <i>Heart</i> | | 90. DECEASED ORGAN <i>Heart</i> | |
| 91. DECEASED ORGAN <i>Heart</i> | | 92. DECEASED ORGAN <i>Heart</i> | | 93. DECEASED ORGAN <i>Heart</i> | |
| 94. DECEASED ORGAN <i>Heart</i> | | 95. DECEASED ORGAN <i>Heart</i> | | 96. DECEASED ORGAN <i>Heart</i> | |
| 97. DECEASED ORGAN <i>Heart</i> | | 98. DECEASED ORGAN <i>Heart</i> | | 99. DECEASED ORGAN <i>Heart</i> | |
| 100. DECEASED ORGAN <i>Heart</i> | | 101. DECEASED ORGAN <i>Heart</i> | | 102. DECEASED ORGAN <i>Heart</i> | |

BUREAU V. 2

OCT 5 1956

RECEIVED

John F. Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. No burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9454 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09436

Reg. Dist. No. 217

| | | | |
|--|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN 1b 6 hrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. Gen. Hosp. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Virgie Middle Virginia Last Edwards | | 4. DATE OF DEATH Month 9 Day 3 Year 56 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1911 ? |
| 9. AGE (In years last birthday) 45 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME A. C. Cameron | | 14. MOTHER'S MAIDEN NAME Nellie Figgins | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Ruby Mc Donald | | Address Simpsonville Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 331X (c) 8 hrs. | | INTERVAL BETWEEN ONSET AND DEATH 8 hrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Contusion rt. temporal (external) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-6-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Liberty Baptist | | 22d. LOCATION (City, town, or county) (State) Lisbon, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R. Selby, 401 Washington Blvd. Laurel, Md | | 24a. REC'D BY REGISTRAR SEP 10 1956 | |
| | | 24b. REGISTRAR'S SIGNATURE Bertrude Lamber | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|---|--|
| NAME OF DECEASED [Illegible] | | SEX [Illegible] | | AGE [Illegible] | |
| PLACE OF BIRTH [Illegible] | | OCCUPATION [Illegible] | | CAUSE OF DEATH [Illegible] | |
| DATE OF DEATH [Illegible] | | TIME OF DEATH [Illegible] | | PLACE OF DEATH [Illegible] | |
| SIGNATURE OF MEDICAL EXAMINER [Illegible] | | SIGNATURE OF DECEASED [Illegible] | | SIGNATURE OF WITNESS [Illegible] | |
| CERTIFICATE NO. [Illegible] | | COUNTY [Illegible] | | CITY [Illegible] | |
| STATE [Illegible] | | ZIP CODE [Illegible] | | TELEPHONE [Illegible] | |
| MEDICAL EXAMINER'S OFFICE [Illegible] | | MEDICAL EXAMINER'S ADDRESS [Illegible] | | MEDICAL EXAMINER'S PHONE [Illegible] | |

BUREAU V. 1

SEP 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9465

CERTIFICATE OF DEATH

09437

Reg. Dist. No. 215

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY Columbia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| c. LENGTH OF STAY IN 1b 3 days | | 47X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | d. STREET ADDRESS 5808-B Lane St., N.E. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Doris Middle Louise Last EVANS | | 4. DATE OF DEATH Month September Day 7 Year 1956 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 23 August 1956 |
| 9. AGE (In years last birthday) yrs. 15 | | IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min. 15 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Joseph Evans | | 14. MOTHER'S MAIDEN NAME Wilhelmia Minor | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT (Father) Joseph Evans (Same As #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyper Kalemia 764.0 DUE TO Renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute gastro-enteritis DUE TO (c) Acute gastro-enteritis | | INTERVAL BETWEEN ONSET AND DEATH 24 hours 48 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4 Sept. , 19 56 , to 7 Sept. , 19 56 , that I last saw the deceased alive on 7 Sept. , 19 56 , and that death occurred at 5:00P. M, from the causes and on the date stated above. | | DATE SIGNED 9-10-56 | |
| ACTUAL SIGNATURE Charles Waite M.D. | | ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. | |
| PHYSICIAN'S NAME (Type) Charles Waite, CDR, MC, USN | | U.S. Naval Hospital, Bethesda, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-12-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Malvan & Shey Funeral Home, 424 "R" St., N.W. | | 24a. REC'D BY REGISTRAR DATE 9-9-56 | |
| 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly | | | |

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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BUREAU V.

SEP 13 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09438

Item 6 FilmG204 9-21-56 et

9466 CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | | | | | |
|---|---|---|---|---|---|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Montgomery</u> | | STATE <u>MARYLAND</u> | | STATE <u>D.C.</u> | | COUNTY | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Silver Spring</u> | | LENGTH OF STAY (in this place) <u>10 mo</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | | <u>47X-3</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cedar Haven Rest Home 7300 Baltimore Ave.</u> | | | | STREET ADDRESS (If rural give location) <u>1400 Fairmont St. N.W.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>August</u> (First) <u>Fast</u> (Middle) (Last) | | | | 4. DATE OF DEATH (Month) <u>Sept</u> (Day) <u>14</u> (Year) <u>1956</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u> | 8. DATE OF BIRTH <u>Feb 4, 1866</u> | 9. AGE last birthday <u>90</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance & Real Estate</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <u>Emery Fast son</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| <u>420.1</u> IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u> | | | | | | <u>72 hrs</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Heart Disease</u> | | | | | | <u>10 yrs</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis - General</u> | | | | | | <u>20 yrs</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>7-17</u>, 19<u>53</u>, to <u>9-14</u>, 19<u>56</u>, that I last saw the deceased alive on <u>9-13</u>, 19<u>56</u>, and that death occurred at <u>9:56 AM</u>, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Joseph H. Watson</u> | | M.D. <u>1822 Baltimore St. Wash</u> | | DATE SIGNED <u>9-14-56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u> | | DATE THEREOF <u>9/14/56</u> | | NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u> | | LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u> | |
| 24. REC'D BY REGISTRAR <u>9/17/56</u> | | REGISTRAR'S SIGNATURE <u>Frances Potter</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. NW</u> | | ADDRESS <u>Washington 9, D.C.</u> | |

CERTIFICATE OF DEATH

ARMY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

Form No. 100

1. NAME (PRINT OR TYPE)

2. PLACE OF DEATH

3. SEX

4. AGE

5. RACE

6. OCCUPATION

7. DATE OF BIRTH

8. PLACE OF BIRTH

9. CAUSE OF DEATH

10. MEDICAL HISTORY

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. DATE OF DEATH

14. TIME OF DEATH

15. PLACE OF INTERMENT

16. NAME OF CEMETERY

17. NAME OF FUNERAL HOME

18. NAME OF MINISTER

19. NAME OF CHURCH

20. NAME OF SOCIETY

21. NAME OF ORGANIZATION

22. NAME OF ASSOCIATION

23. NAME OF CLUB

24. NAME OF ORDER

25. NAME OF LODGE

26. NAME OF GUILD

27. NAME OF SOCIETY

28. NAME OF ORDER

29. NAME OF LODGE

30. NAME OF GUILD

31. NAME OF SOCIETY

32. NAME OF ORDER

33. NAME OF LODGE

34. NAME OF GUILD

35. NAME OF SOCIETY

36. NAME OF ORDER

37. NAME OF LODGE

38. NAME OF GUILD

39. NAME OF SOCIETY

40. NAME OF ORDER

41. NAME OF LODGE

42. NAME OF GUILD

43. NAME OF SOCIETY

44. NAME OF ORDER

45. NAME OF LODGE

46. NAME OF GUILD

47. NAME OF SOCIETY

48. NAME OF ORDER

49. NAME OF LODGE

50. NAME OF GUILD

51. NAME OF SOCIETY

52. NAME OF ORDER

53. NAME OF LODGE

54. NAME OF GUILD

55. NAME OF SOCIETY

56. NAME OF ORDER

INSTRUCTIONS

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R. A. R.

7-17-66
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R. A. R.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9413 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09439
Reg. Dist. No. 223

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>42 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> <u>47X-3</u> d. STREET ADDRESS <u>5316 Illinois Ave., N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Christie Heikel Fesler</u> | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> Year <u>1956</u> | | 5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 4, 1884</u> 9. AGE (In years last birthday) <u>71</u> yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>ATTORNEY office</u> 11. BIRTHPLACE (State or foreign country) <u>Penna.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>George Fesler</u> 14. MOTHER'S MAIDEN NAME <u>Mary Heikel</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Hospital Records</u> Address _____ | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO (b) <u>Carcinoma Rectum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>1 yr</u> </div> </div> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Raymond O. West</u> (M.D.) EXAMINER'S NAME (Type) _____ CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>9-22-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u> | | ADDRESS <u>4812 9th Ave N.W.</u> | | 24a. REC'D BY REGISTRAR <u>9/22/56</u> | | | |
| 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 24c. LOCATION (City, town, or county) <u>BLADENSBURG</u> (State) <u>M.D.</u> | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

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SEP 25 1956

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9467

CERTIFICATE OF DEATH

09440

Reg. Dist. No. 215

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 8 mos. 6 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miami | | d. STREET ADDRESS 1899 N.W. 3rd Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Charles Middle Stanley Last FINCH | | 4. DATE OF DEATH Month September Day 11 Year 19 56 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3 July 1896 |
| 9. AGE (In years last birthday) yrs. 60 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) M.S. Marine Corps | | 10b. KIND OF BUSINESS OR INDUSTRY USMC (Retired) | |
| 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Ervin H. FINCH | | 14. MOTHER'S MAIDEN NAME Nellie Mae Seymour | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Mrs. Nina B. FINCH (Wife) (Same As #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis from Organism undet. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO (c) | | | |
| INTERVAL BETWEEN ONSET AND DEATH 7 days 15 yrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 5 , 19 56 , to Sept. 11 , 19 56 , that I last saw the deceased alive on 11 Sept. , 19 56 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE H.E. Richardson | | ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. | |
| DATE SIGNED 9-12-56 | | | |
| PHYSICIAN'S NAME (Type) H.E. RICHARDSON, CAPT, MC, USN | | U.S. Naval Hospital, Bethesda, Md. 9-12-56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 17-Sept. 56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey | | ADDRESS Bethesda, Md. | |
| 24a. REC'D BY REGISTRAR DATE 9-12-56 | | 24b. REGISTRAR'S SIGNATURE May E. Farrelly | |

BUREAU V. S.

SEP 13 1956

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9468

CERTIFICATE OF DEATH

09441

Reg. Dist. No. 215

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Arlington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Bethesda) | c. LENGTH OF STAY IN 1b DOA | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION En Route to U.S. NavHosp. Bethesda, Md. | | d. STREET ADDRESS 1205 S. Thomas Street | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Madeleine Middle Jetmore Last FORTUNE | | 4. DATE OF DEATH Month September Day 10 Year 19 56 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-24-1900 |
| 9. AGE (In years last birthday) 55 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | 11. BIRTHPLACE (State or foreign country) Kansas |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME Harvey Jetmore | |
| 14. MOTHER'S MAIDEN NAME Grace Music | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Official Navy Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma with metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH 1 year |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 10 Sept. , 19 56 , to 10 Sept. , 19 56 , that I last saw the deceased alive on 10 Sept. , 19 56 , and that death occurred at 12:35 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE George E. Vaupel | | ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. | |
| PHYSICIAN'S NAME (Type) George E. Vaupel, CDR, MC, USN | | DATE SIGNED 10 Sept. 56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9-13-56 | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, 2847 Wilson Blvd., Arlington | | 24a. REC'D BY REGISTRAR DATE 9-10-56 | 24b. REGISTRAR'S SIGNATURE Harry E. Farrelly |

SEP 13 1956

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9469

CERTIFICATE OF DEATH

09442

Reg. Dist. No.

214

| | | | |
|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HILLENDALE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HILLENDALE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1906 Forest Dale Drive | | d. STREET ADDRESS 1906 FOREST DALE DRIVE | |
| 3. NAME OF DECEASED (Type or print) First GERTRUDE Middle PEARL Last FRAZIER | | 4. DATE OF DEATH Month 9 Day 24 Year 1956 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/3/1889 |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frank Reamer | | 14. MOTHER'S MAIDEN NAME ----- Davis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | |
| 17. INFORMANT Mrs. Dorothy F. Basye- | | Address 1906 Forest Dale Dr., Hillendale, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-vascular-renal disease DUE TO (c) Diabetes Mellitis | | | INTERVAL BETWEEN ONSET AND DEATH 2 mos 2 yrs 12 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) gangrene - right foot | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/9/44 , 19___, to 9/24/56 , 19___, that I last saw the deceased alive on 9/24/56 , 19___, and that death occurred at 12:05 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Robt. J. Bosworth | | DATE SIGNED 811-8-N.E. | |
| PHYSICIAN'S NAME (Type) ROBT. J. BOSWORTH, M.D. | | Wash @ D.C. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9/26/56 | 22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | 22d. LOCATION (City, town, or county) (State) Washington, D.C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. | | 24a. REC'D BY REGISTRAR 9/26/56 | |
| ADDRESS 2901 14th St., N.W. | | 24b. REGISTRAR'S SIGNATURE Francis Potter | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|------------------------|--|----------------------|--|-----------------------|--|----------------------|--|--------------------|--|--------------------------|--|------------------------|--|---------------------|--|--------------------|--|---------------------|--|----------------------------|--|----------------------------|--|------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF PHYSICIAN | | 13. SIGNATURE OF CLERK | | 14. SIGNATURE OF WITNESSES | |
| JOHN J. JONES | | M | | 45 | | W | | JAN 15 1910 | | BALTIMORE, MD | | JAN 15 1956 | | BALTIMORE, MD | | HEART DISEASE | | NATURAL | | J. J. JONES | | J. J. JONES | | J. J. JONES | | J. J. JONES | |
| 15. PLACE OF INTERMENT | | 16. NAME OF CEMETERY | | 17. DATE OF INTERMENT | | 18. NAME OF MINISTER | | 19. NAME OF CHURCH | | 20. NAME OF FUNERAL HOME | | 21. NAME OF UNDERTAKER | | 22. NAME OF CARRIER | | 23. NAME OF COFFIN | | 24. NAME OF CASK | | 25. NAME OF CASK | | 26. NAME OF CASK | | 27. NAME OF CASK | | 28. NAME OF CASK | |
| BALTIMORE, MD | | BALTIMORE, MD | | JAN 15 1956 | | J. J. JONES | | BALTIMORE, MD | | BALTIMORE, MD | | BALTIMORE, MD | | BALTIMORE, MD | | BALTIMORE, MD | | BALTIMORE, MD | | BALTIMORE, MD | | BALTIMORE, MD | | BALTIMORE, MD | | BALTIMORE, MD | |

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SEP 28 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9470

CERTIFICATE OF DEATH

09443

Reg. Dist. No. 215

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 1 Mo. 4 days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | | |
| d. STREET ADDRESS 8234 New Hampshire Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Philip Middle (none) Last FRIEDMAN | | | | 4. DATE OF DEATH Month Sept. Day 4 Year 1956 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Hebrew W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 24 March 1922 | |
| 9. AGE (In years last birthday) 34 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy | | | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Louis Friedman | | | | 14. MOTHER'S MAIDEN NAME Yetta SACHS | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-II | | | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Official Navy Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma, nec, abdomen 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH 3 mo. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 30 July , 19 56 , to 4 Sept , 19 56 , that I last saw the deceased alive on 4 Sept. , 19 56 , and that death occurred at 6:00A. M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE H.E. Richardson | | | | ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-4-56 | | | |
| PHYSICIAN'S NAME (Type) H.E. RICHARDSON, CAPT, MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-5-56 | | 22c. NAME OF CEMETERY OR CREMATORY Keshet Israel Cemetery | | 22d. LOCATION (City, town, or county) (State) Washington, D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Danzansky Funeral Home 3501 14th St., N.W. | | | | ADDRESS Washington, D.C. | | 24a. REC'D BY REGISTRAR DATE 9-4-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE May E. Russell Jr. | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

SEP 5 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09444

9414

CERTIFICATE OF DEATH

Reg. Dist. No.

773

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>28 hrs.</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | 56 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | d. STREET ADDRESS <u>11600 Georgia Ave.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Selma</u> Middle <u>(none)</u> Last <u>Friedman</u> | | 4. DATE OF DEATH Month <u>September</u> Day <u>26</u> Year <u>1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-15-80</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | |
| 13. FATHER'S NAME <u>Seligman Rothschild</u> | | 14. MOTHER'S MAIDEN NAME <u>Hannah Burk</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-----</u> | |
| 17. INFORMANT <u>Hospital Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial infarction</u> DUE TO (c) <u>Hypertensive Heart disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>Unknown</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1954</u> to <u>26 Sept. 1956</u> , that I last saw the deceased alive on <u>25 Sept. 1956</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above. | | | |
| ADDRESS (Street, city or town, state) <u>11602 Georgia Ave. Silver Spring, Md.</u> | | DATE SIGNED <u>9-26-56</u> | |
| ACTUAL SIGNATURE <u>Morris Perry</u> | | M.D. <u>11602 Georgia Ave. Silver Spring, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Morris Perry</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 22b. DATE THEREOF <u>9-28-56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>David R. Martin</u> | | ADDRESS <u>1902 Rutaw P St</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE 28 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. Nelson Saddy</u> | |

BUREAU V. S.

SEP 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09445

9471

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 24 1/4 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 4. DATE OF DEATH First Gladys Middle Velma Last Fulton | | 4. DATE OF DEATH Month September 9 Day 19 Year 56 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 15, 1899 |
| 9. AGE (In years last birthday) 57 yrs. | | IF UNDER 1 YEAR Months 0 Days 24 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Iowa | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Henry Lohrer | | 14. MOTHER'S MAIDEN NAME Julia Lovelett | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT The Medical Record | | Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the breast DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 9, 1956 , to September 9, 1956 , that I last saw the deceased alive on September 9, 1956 , and that death occurred at 7:25 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James R. Jude | | DATE SIGNED 9/9/56 | |
| PHYSICIAN'S NAME (Type) James R. Jude, M.D. | | ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 22b. DATE THEREOF 9-11-56 | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | 22d. LOCATION (City, town, or county) (State) Prince Georges Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | ADDRESS Bethesda, Md. | |
| 24a. REC'D BY REGISTRAR DATE 9-10-56 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9472

CERTIFICATE OF DEATH

09446

Reg. Dist. No.

217

| | | | |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | c. LENGTH OF STAY IN 1b <u>3 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u> | | d. STREET ADDRESS <u>Hyattstown</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Hume Funk</u> | | 4. DATE OF DEATH Month Day Year <u>September 8 1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/17/82</u> |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Kentucky</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Thomas Funk</u> | | 14. MOTHER'S MAIDEN NAME <u>Frances Ann Hocker</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>219-34-3946</u> | |
| 17. INFORMANT Address <u>Hospital Recrod (Wife)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Myocardial Infarction (2)</u> DUE TO (b) <u>Atherosclerosis, Coronary Vessels</u> DUE TO (c) <u>Interruption of Coronary Vessels</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Basal broncho-pneumonia congestive</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9/5</u> , 19 <u>56</u> , to <u>9/8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/7</u> , 19 <u>56</u> , and that death occurred at <u>12:47 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>G. F. Meadors, M.D.</u> | | ADDRESS (Street, city or town, state) <u>Damascus, Maryland</u> | |
| DATE SIGNED <u>9/9/56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>G. F. Meadors, M. D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Sept 10 1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Beane Creek Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Beane Creek, Md. Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Barth J. Hume</u> | | ADDRESS <u>Barth J. Hume</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE 13 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>Gertrude Lawler</u> | |

CERTIFICATE OF DEATH

| | | | |
|--|--|-----------------------------------|--|
| PLACE OF BIRTH COUNTY OF _____ STATE OF _____ | | MARRIED YES _____ NO _____ | |
| DATE OF BIRTH _____ | | PLACE OF DEATH _____ | |
| SEX MALE _____ FEMALE _____ | | RACE _____ | |
| OCCUPATION _____ | | CAUSE OF DEATH _____ | |
| DATE OF DEATH _____ | | TIME OF DEATH _____ | |
| PLACE OF DEATH _____ | | NAME OF PHYSICIAN _____ | |
| NAME OF DECEASED _____ | | NAME OF NEXT OF KIN _____ | |
| ADDRESS OF DECEASED _____ | | ADDRESS OF NEXT OF KIN _____ | |
| CITY OF DECEASED _____ | | CITY OF NEXT OF KIN _____ | |
| STATE OF DECEASED _____ | | STATE OF NEXT OF KIN _____ | |
| COUNTY OF DECEASED _____ | | COUNTY OF NEXT OF KIN _____ | |
| ZIP CODE OF DECEASED _____ | | ZIP CODE OF NEXT OF KIN _____ | |
| SIGNATURE OF DECEASED _____ | | SIGNATURE OF NEXT OF KIN _____ | |
| DATE OF SIGNATURE _____ | | DATE OF SIGNATURE _____ | |
| PLACE OF SIGNATURE _____ | | PLACE OF SIGNATURE _____ | |
| NAME OF WITNESS _____ | | NAME OF WITNESS _____ | |
| ADDRESS OF WITNESS _____ | | ADDRESS OF WITNESS _____ | |
| CITY OF WITNESS _____ | | CITY OF WITNESS _____ | |
| STATE OF WITNESS _____ | | STATE OF WITNESS _____ | |
| COUNTY OF WITNESS _____ | | COUNTY OF WITNESS _____ | |
| ZIP CODE OF WITNESS _____ | | ZIP CODE OF WITNESS _____ | |
| SIGNATURE OF WITNESS _____ | | SIGNATURE OF WITNESS _____ | |
| DATE OF SIGNATURE _____ | | DATE OF SIGNATURE _____ | |
| PLACE OF SIGNATURE _____ | | PLACE OF SIGNATURE _____ | |

RECEIVED

BUREAU V. S.
SEP. 13 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9415 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09447

223

| | | | |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Pa. b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | c. LENGTH OF STAY IN 1b D.O.A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San. & Hosp. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frackville | |
| 3. NAME OF DECEASED (Type or print) First Ralph Middle Galati Last Galati | | 4. DATE OF DEATH Month 9/11/56 Day 19 Year 19 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/15/97 |
| 9. AGE (In years last birthday) 39 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) contractor | | 10b. KIND OF BUSINESS OR INDUSTRY Italy | |
| 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Nicole Galati | | 14. MOTHER'S MAIDEN NAME Flavia Lotortor | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0 | | 16. SOCIAL SECURITY NO. 202-10-6763 | |
| 17. INFORMANT Address Mrs. Helen H. Galati, 103 Oak St. Frackville, Pa. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 9/11/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) Frackville, Schuyl County, Pa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS Silver Spring, Md. | | 24a. REC'D BY REGISTRAR DATE 9/13/56 | |
| | | 24b. REGISTRAR'S SIGNATURE J. H. H. H. H. | |

117 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Silver Spring</u> | | | | c. LENGTH OF STAY IN 1b <u>20 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedarcroft Sanitarium & Hospital</u> | | | | d. STREET ADDRESS <u>5400 Christy Drive</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>J.</u> Last <u>Garrahan</u> | | | | 4. DATE OF DEATH Month <u>September</u> Day <u>22</u> Year <u>1956</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 2, 1885</u> | | 9. AGE (In years last birthday) <u>71 yrs.</u> | IF UNDER 1 YEAR Months <u>7</u> Days <u>20</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney Ret.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>M.D. Kirkpatrick, 5400 Christy Dr.</u> | | | |
| | | | | Address <u>Springfield Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>322.2</u> DUE TO <u>Terminal broncho pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lowered resistance from alcoholism</u> DUE TO (c) <u>Chronic brain syndrome & cerebral arteriosclerosis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>around 2 weeks</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome & cerebral arteriosclerosis</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9-2</u> , 19 <u>56</u> to <u>9-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-22</u> , 19 <u>56</u> , and that death occurred at <u>3:20 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Alvin J. Kistler</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Cedarcroft Sanitarium & Hospital, Silver Spring, Md.</u> | | DATE SIGNED <u>9/26/56</u> | |
| PHYSICIAN'S NAME (Type) <u>Alvin J. Kistler, M. D.</u> | | | | ADDRESS <u>R.F.D. 2 Columbia Road Silver Spring, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9-25-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince Georges Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | | | ADDRESS <u>Bethesda Md</u> | | 24a. REC'D BY REGISTRAR <u>9/26/56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Shances</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5409 Chisly Drive

References

BUREAU V. S.

SEP 28 1956

RECEIVED

9474

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | d. STREET ADDRESS <u>2087 Harrison St.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Catherine</u> Last <u>Gates</u> | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 18, 1874</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>John Gates</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>Lola Haines-</u> | | Address <u>32 W. Montg. Ave., Rockville, Md.</u> | |

| | | | |
|---|---|---|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinoma</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of stomach</u> DUE TO (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u> <u>6 min.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arterial occlusion of left leg</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m. <u></u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Sept 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/22/57</u> , 19 <u>57</u> , and that death occurred at <u>3:50 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D. | | ADDRESS (Street, city or town, state) <u>Rockville Md</u> DATE SIGNED <u>9/22/56</u> | |
| PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u> | | <u>Rockville, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>9/25/56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u> | 22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> | | 24a. REC'D BY REGISTRAR <u>9-25-56</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 3 and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9475

CERTIFICATE OF DEATH

09450

Reg. Dist. No. 216

| | | | |
|---|---------------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>FLORIDA</u> b. COUNTY <u>DADE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RETHESDA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAMPA</u> | |
| c. LENGTH OF STAY IN 1b <u>2 days</u> | | d. STREET ADDRESS <u>208 So. Hines Avenue</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>GEIGER</u> Last <u>GEIGER</u> | | 4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/29/77</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>WILLIAM GEIGER</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>Mrs. Elizabeth Delaney</u> Address <u>Washington, D.C.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO <u>20 days</u> (c) <u>Arteriosclerotic Heart Disease</u> <u>20 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept 17</u> , 19 <u>56</u> , to <u>Sept 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 26</u> , 19 <u>56</u> , and that death occurred at <u>11 P.</u> M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Michael M. Healy</u> M.D. | | ADDRESS (Street, city or town, state) <u>Washington Clinic Wash D.C.</u> DATE SIGNED <u>9/26/56</u> | |
| PHYSICIAN'S NAME (Type) <u>MICHAEL M. HEALY</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>9/29/56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>ROCKVILLE UNION CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>ROCKVILLE, MONTGOMERY CO., MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u> | | 24a. REC'D BY REGISTRAR <u>9/28/56</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|----------------------------|--|---------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|----------------------------|--|---------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF DECEASED | |
| JAMES EARL RAY | | M | | 35 | | W | | 1928 | | MEMPHIS, TENN | | APR 4, 1968 | | MEMPHIS, TENN | | HEART DISEASE | | NATURAL | | | | | |
| 13. OCCUPATION | | 14. EDUCATION | | 15. MARITAL STATUS | | 16. RELIGION | | 17. PREVIOUS ILLNESS | | 18. PREVIOUS SURGERY | | 19. PREVIOUS TRAUMA | | 20. PREVIOUS DRUGS | | 21. PREVIOUS ALCOHOL | | 22. PREVIOUS TOBACCO | | 23. PREVIOUS OTHER | | 24. PREVIOUS OTHER | |
| ATTORNEY | | HIGH SCHOOL | | MARRIED | | METHODIST | | NONE | | NONE | | NONE | | NONE | | NONE | | NONE | | NONE | | NONE | |
| 25. SIGNATURE OF REGISTRAR | | 26. SIGNATURE OF DECEASED | | 27. SIGNATURE OF WITNESS | | 28. SIGNATURE OF WITNESS | | 29. SIGNATURE OF WITNESS | | 30. SIGNATURE OF WITNESS | | 31. SIGNATURE OF WITNESS | | 32. SIGNATURE OF WITNESS | | 33. SIGNATURE OF WITNESS | | 34. SIGNATURE OF WITNESS | | 35. SIGNATURE OF WITNESS | | 36. SIGNATURE OF WITNESS | |
| | | | | | | | | | | | | | | | | | | | | | | | |

RECEIVED
OCT 1 1966
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9476

CERTIFICATE OF DEATH

09451
Reg. Dist. No. 211

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Clarence Norton Goodwin | | 4. DATE OF DEATH Month Day Year Sept. 21 19 56 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 22, 1871 |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Penn Yan, New York | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Richard LaBarre Goodwin | | 14. MOTHER'S MAIDEN NAME Belle Norton | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. -- | |
| 17. INFORMANT Address Mr. Macdonald Goodwin, Damascus, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Removance 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Arteriosclerotic cardiovascular disease (c) 10 years | | INTERVAL BETWEEN ONSET AND DEATH 3 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8/28 , 19 56 , to 9/21 , 19 56 , that I last saw the deceased alive on 9/21 , 19 56 , and that death occurred at 12:30 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James P. Kerr | | ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 9/21/56 | |
| PHYSICIAN'S NAME (Type) James P. Kerr M.D. | | Damascus, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF Sept. 21, 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | | 22d. LOCATION (City, town, or county) (State) Bladensburg, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Mobern | | ADDRESS Damascus, Md. | |
| 24a. REC'D BY REGISTRAR DATE Sept 24/56 | | 24b. REGISTRAR'S SIGNATURE Della M. Burdette | |

CERTIFICATE OF DEATH

0176

1956-217

| | | | | | |
|--|--|---|--|---|--|
| Name of Deceased James P. Hart | | Sex Male | | Age 45 | |
| Date of Death Sept. 21, 1956 | | Place of Death Home | | Cause of Death Myocardial Infarction | |
| Manner of Death Natural | | Occupation Engineer | | Usual Residence 1234 Main St., Baltimore, Md. | |
| Date of Birth Sept. 22, 1911 | | Place of Birth St. Louis, Mo. | | Marital Status Married | |
| Name of Spouse Elizabeth Hart | | Name of Physician Dr. J. H. Smith | | Name of Coroner John A. Jones | |
| Signature of Physician <i>[Signature]</i> | | Signature of Coroner <i>[Signature]</i> | | Signature of Registrar <i>[Signature]</i> | |
| Date of Report Sept. 22, 1956 | | Time of Report 10:00 AM | | Place of Report Baltimore, Md. | |

BUREAU A. 2

SEP 24 - 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9477 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09452
Reg. Dist. No. 218

| | | | | | | | |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg | | c. LENGTH OF STAY IN 1b 23 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg/ Spencerville | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Asbury Methodist Home | | | | d. STREET ADDRESS Asbury Methodist Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Jacqueline Maud Graybill | | | | 4. DATE OF DEATH Month Day Year Sept 4, 1956 19 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4/16/67 | | 9. AGE (In years last birthday) 89 yrs. | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical nurse | | 10b. KIND OF BUSINESS OR INDUSTRY Nursing | | 11. BIRTHPLACE (State or foreign country) Va. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Lewis Graybill | | | | 14. MOTHER'S MAIDEN NAME Mary W. Taylor | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Home records As 1-D Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Contusion of forehead and rt. eye | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 hr. | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 9-7-56 | | 22c. NAME OF CEMETERY OR CREMATORY Elbethel Church Cemetery, Buchanan Va | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Frank J. Broschart | | | | 24a. REC'D BY REGISTRAR 2nd | | 24b. REGISTRAR'S SIGNATURE Abner L. Cooke | |

DATE SIGNED

9/4/56

BUREAU V. 5

SEP 10 1956

SEP 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09453

9478

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> | | c. LENGTH OF STAY IN 1b <u>15 days</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u> |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u> | | d. STREET ADDRESS <u>134 Thomas St., N.W.</u> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Armanda</u> Middle <u>(none)</u> Last <u>GREEN</u> | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>30</u> Year <u>1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>20 Jan. 1914</u> |
| 9. AGE (In years last birthday) <u>42</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. FATHER'S NAME <u>Bradley MC KAY</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Carrie Watson</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT <u>Official Navy Records</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Failure</u> DUE TO <u>Electrocardiogram</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Overweight</u> (c) <u>Tuberculosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>joint & muscular system disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>36 hours</u> <u>8 years</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>15 Sept.</u> , 19 <u>56</u> , to <u>30 Sept.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>30 Sept.</u> , 19 <u>56</u> , and that death occurred at <u>9:20A</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>C. C. Muehe</u> | | ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>10-1-56</u> | |
| PHYSICIAN'S NAME (Type) <u>C. C. MUEHE, CDR, MC, USN</u> | | <u>U.S. Naval Hospital, Bethesda, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10-7-56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Beauty Spot Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Fairmont, North Carolina</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Bacons Funeral Home, 1722 7th St., N.W.,</u> | | 24a. REC'D BY REGISTRAR <u>DATE 10-1-56</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Thos. E. Passelty</u> | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Form 100-101

| | | | | | | | | | |
|------------------------|--|-------------------------|--|--------------------------|--|---------------|--|---------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | MALE | | 35 | | JAN 5 1928 | | MOBILE, ALABAMA | |
| MARRIAGE | | DATE OF MARRIAGE | | PLACE OF MARRIAGE | | DATE OF DEATH | | PLACE OF DEATH | |
| MARRIED | | JAN 15 1954 | | BALTIMORE, MARYLAND | | JAN 4 1968 | | BALTIMORE, MARYLAND | |
| OCCUPATION | | DATE OF OCCUPATION | | PLACE OF OCCUPATION | | DATE OF DEATH | | PLACE OF DEATH | |
| CONDUCTOR | | JAN 15 1954 | | BALTIMORE, MARYLAND | | JAN 4 1968 | | BALTIMORE, MARYLAND | |
| CAUSE OF DEATH | | DATE OF CAUSE OF DEATH | | PLACE OF CAUSE OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | |
| HEART DISEASE | | JAN 15 1954 | | BALTIMORE, MARYLAND | | JAN 4 1968 | | BALTIMORE, MARYLAND | |
| MANNER OF DEATH | | DATE OF MANNER OF DEATH | | PLACE OF MANNER OF DEATH | | DATE OF DEATH | | PLACE OF DEATH | |
| NATURAL | | JAN 15 1954 | | BALTIMORE, MARYLAND | | JAN 4 1968 | | BALTIMORE, MARYLAND | |
| SIGNATURE OF PHYSICIAN | | DATE OF SIGNATURE | | PLACE OF SIGNATURE | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES EARL RAY | | JAN 15 1954 | | BALTIMORE, MARYLAND | | JAN 4 1968 | | BALTIMORE, MARYLAND | |
| SIGNATURE OF REGISTRAR | | DATE OF SIGNATURE | | PLACE OF SIGNATURE | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES EARL RAY | | JAN 15 1954 | | BALTIMORE, MARYLAND | | JAN 4 1968 | | BALTIMORE, MARYLAND | |

BUREAU V. 8

1956 8 1001

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. No burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9479

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film 204 10-1-56 et

09454

Reg. Dist. No.

216

| | | | | | | | | | |
|---|--|-------------------------------|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>116 Grafton St</u> | | | | d. STREET ADDRESS <u>116 Grafton St</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Herman Franklin Hancock</u> | | | | 4. DATE OF DEATH Month Day Year <u>Sept 24 1956</u> | | | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-6-1886</u> | | | |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>druggist</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u> | | | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME <u>Cimrose Hancock</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mother: Druscilla Jones</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | | | | |
| 17. INFORMANT <u>William R. Hancock (wife)</u> | | | | Address <u>116 Grafton St</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dead in bed.</u> DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u> | | | | 22b. DATE THEREOF <u>Sept. 28/56</u> | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Episcopal</u> | | | | 22d. LOCATION (City, town, or county) (State) <u>Snook Hill, MD</u> | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Thomas, Snook Hill, MD</u> | | | | 24a. REC'D BY REGISTRAR <u>SEP 28 1956</u> | | | | | |
| 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u> | | | | | | | | | |

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

9450

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09455

Items 8&9 Film G205 10/11/56

CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | c. LENGTH OF STAY IN 1b 3 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 516 THAYER AVENUE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last HANKINS | | 4. DATE OF DEATH Month SEPT. Day 26 Year 19 56 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/29/87/ 1897 |
| 9. AGE (In years last birthday) 58 68 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDER (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS | |
| 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN HANKINS | | 14. MOTHER'S MAIDEN NAME MARIE BAYLIS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 578-22-5676 | |
| 17. INFORMANT Mrs. Evelyn M. Hankins, 516 Thayer Ave. | | Address Silver Spring, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive heart disease DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 6 yrs 6 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/7 , 19 50 , to 9/26 , 19 56 , that I last saw the deceased alive on 9/26 , 19 56 , and that death occurred at 1:55 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE J. D. Demaree | | ADDRESS (Street, city or town, state) 5801-13th St. NW. 9/26/56 | |
| DATE SIGNED 9/26/56 | | DATE SIGNED 9/26/56 | |
| PHYSICIAN'S NAME (Type) H. C. LEONARD G | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL | | 22b. DATE THEREOF 9/29/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY MT. VERNON CEMETERY | | 22d. LOCATION (City, town, or county) (State) McKEESPORT, PENNSYLVANIA | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey | | ADDRESS SILVER SPRING, MD. | |
| 24a. REC'D BY REGISTRAR DATE 9/30/56 | | 24b. REGISTRAR'S SIGNATURE James Potter | |

MAY AND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

OCT 4 1956

BUREAU V. S.

RECEIVED

9481

CERTIFICATE OF DEATH

Reg. Dist. No. 218

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> | | c. LENGTH OF STAY IN 1b <u>117m -</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvary Methodist Home</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>HANSON</u> Last <u>HANSON</u> | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 1st 1874</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>16</u> Days <u>2</u> Hours <u>-</u> Min. <u>-</u> | 11. IF UNDER 24 HRS. Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher & office work</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Freight</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Frederick Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Hanson</u> | | 14. MOTHER'S MARYDEN NAME <u>Frances Pagan</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>214-10-4705</u> | |
| 17. INFORMANT <u>Calvary Methodist Home (Records)</u> | | Address <u>Gaithersburg Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u>-</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>-</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>JAN.</u> , 19 <u>56</u> , to <u>Sept</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>AUGUST 29</u> , 19 <u>56</u> , and that death occurred at <u>12:30a</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4208 ANTHONY ST. Kensington Md</u> DATE SIGNED <u>9-3-56</u> | | | |
| ACTUAL SIGNATURE <u>Sarah E. Glover</u> | | M.D. <u>4208 ANTHONY ST. Kensington Md</u> | |
| PHYSICIAN'S NAME (Type) <u>Sarah E. Glover</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | 22b. DATE THEREOF <u>9-5-56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Frederick Memorial</u> | 22d. LOCATION (City, town, or county) (State) <u>Frederick Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Darr</u> | | ADDRESS <u>Frederick Md</u> | |
| 24a. REC'D BY REGISTRAR <u>Sept. 5-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Abraham H. Coale</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1951

MARRIAGE

DATE OF MARRIAGE

PLACE OF MARRIAGE

NAME OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

NAME OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

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DATE OF DEATH

PLACE OF DEATH

NAME OF DEATH

BUREAU V. S.

SEP 2 1956

RECEIVED

9416

CERTIFICATE OF DEATH

Reg. Dist. No.

723

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | | c. LENGTH OF STAY IN 1b <u>11 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Rezin</u> Last <u>Hardisty</u> | | | | 4. DATE OF DEATH Month <u>September</u> Day <u>17</u> Year <u>1956</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>October 22, 1873</u> | |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Life Insurance</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Rezin Hardisty</u> | | | | 14. MOTHER'S M maiden NAME <u>Amanda Hopkins</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u> | | | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT <u>Charts and Records - Washington San. and Hosp.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of the Prostate</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Prostate</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>2 years</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>2 Sept</u> , 19 <u>56</u> , to <u>17 Sept</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>17 Sept</u> , 19 <u>56</u> , and that death occurred at <u>1248 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>L.B. Snow</u> | | | | ADDRESS (Street, city or town, state) <u>9013 Flower Ave Silver Spring, Md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>L.B. Snow</u> | | | | DATE SIGNED <u>9/17/56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Cremation</u> | | <u>9-18-56</u> | | <u>Lees Crematory</u> | | <u>Wash. D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>L.W. Lees</u> | | | | ADDRESS <u>300 4th St N.E.</u> | | | |
| 24a. REC'D BY REGISTRAR <u> </u> | | | | 24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u> | | | |
| DATE <u>9/20/56</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and medical history. The form is partially filled out with handwritten text.

BUREAU V. S.

SEP 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9482

Item 2 FilmG202 9-13-56 et

CERTIFICATE OF DEATH

09458

Reg. Dist. No. 216

| | | | | | | |
|--|------------------------------|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 74 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSP. ASSOCIATION | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5804 Aberdeen Road 8400 RIDGEBETHESDA RD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First KATE Middle HARGRAVE Last HARGRAVE | | 4. DATE OF DEATH Month Sept. Day 2 Year 1956 | | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/28/66 | 9. AGE (In years last birthday) 90 yrs. | IF UNDER 1 YEAR Months 90 | IF UNDER 24 HRS. Days 2 Hours 1956 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Edward Payne Cantwell | | | 14. MOTHER'S MAIDEN NAME Ellen Louise Deming | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive heart failure. DUE TO (b) Arteriosclerotic heart disease. DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia, L.L.L. | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from Sept. 2, 1956 to Sept. 2, 1956 that I last saw the deceased alive on Sept. 2, 1956 , and that death occurred at 11:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 104 Chevy Chase Drive, Chevy Chase 15, Md. DATE SIGNED 53 | | | | | | |
| ACTUAL SIGNATURE George A. Gray Jr. | | M.D. Geo. A. GRAY JR. | | DATE SIGNED 9-6-56 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/4/56 | | 22c. NAME OF CEMETERY OR CREMATORY Maplewood | | 22d. LOCATION (City, town, or county) (State) Wilson, N. C. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joe. F. Birch's Son | | ADDRESS 3034 M St. N.W. Wash, D.C. | | 24a. REC'D BY REGISTRAR 9-6-56 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson |

CERTIFICATE OF DEATH

3422

| | | | |
|----------------------------|--|----------------------------|--|
| 1. PLACE OF DEATH | | 2. PLACE OF BIRTH | |
| MONTGOMERY | | MONTGOMERY | |
| 3. COUNTY OF DEATH | | 4. COUNTY OF BIRTH | |
| MONTGOMERY | | MONTGOMERY | |
| 5. DATE OF DEATH | | 6. DATE OF BIRTH | |
| 10-2-58 | | 10-2-58 | |
| 7. TIME OF DEATH | | 8. TIME OF BIRTH | |
| 10:00 AM | | 10:00 AM | |
| 9. SEX | | 10. SEX | |
| M | | M | |
| 11. RACE | | 12. RACE | |
| W | | W | |
| 13. AGE | | 14. AGE | |
| 34 | | 34 | |
| 15. OCCUPATION | | 16. OCCUPATION | |
| Salesman | | Salesman | |
| 17. CAUSE OF DEATH | | 18. CAUSE OF DEATH | |
| Myocardial Infarction | | Myocardial Infarction | |
| 19. MANNER OF DEATH | | 20. MANNER OF DEATH | |
| Natural | | Natural | |
| 21. SIGNATURE OF PHYSICIAN | | 22. SIGNATURE OF PHYSICIAN | |
| [Signature] | | [Signature] | |
| 23. SIGNATURE OF REGISTRAR | | 24. SIGNATURE OF REGISTRAR | |
| [Signature] | | [Signature] | |
| 25. DATE OF REGISTRATION | | 26. DATE OF REGISTRATION | |
| 10-2-58 | | 10-2-58 | |
| 27. NAME OF HOSPITAL | | 28. NAME OF HOSPITAL | |
| St. Elizabeth's Hospital | | St. Elizabeth's Hospital | |
| 29. NAME OF NURSING HOME | | 30. NAME OF NURSING HOME | |
| | | | |
| 31. NAME OF HOME | | 32. NAME OF HOME | |
| Home | | Home | |
| 33. NAME OF PLACE | | 34. NAME OF PLACE | |
| Place | | Place | |
| 35. NAME OF STREET | | 36. NAME OF STREET | |
| Street | | Street | |
| 37. NAME OF CITY | | 38. NAME OF CITY | |
| Baltimore | | Baltimore | |
| 39. NAME OF STATE | | 40. NAME OF STATE | |
| Maryland | | Maryland | |
| 41. NAME OF COUNTRY | | 42. NAME OF COUNTRY | |
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| 43. NAME OF DEPARTMENT | | 44. NAME OF DEPARTMENT | |
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| 45. NAME OF DIVISION | | 46. NAME OF DIVISION | |
| Vital Statistics | | Vital Statistics | |
| 47. NAME OF OFFICE | | 48. NAME OF OFFICE | |
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| 49. NAME OF COUNTY | | 50. NAME OF COUNTY | |
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| 51. NAME OF DISTRICT | | 52. NAME OF DISTRICT | |
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| 53. NAME OF WARD | | 54. NAME OF WARD | |
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| 55. NAME OF ROOM | | 56. NAME OF ROOM | |
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| 57. NAME OF BUILDING | | 58. NAME OF BUILDING | |
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| 59. NAME OF STREET | | 60. NAME OF STREET | |
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| 61. NAME OF CITY | | 62. NAME OF CITY | |
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| 63. NAME OF STATE | | 64. NAME OF STATE | |
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| 65. NAME OF COUNTRY | | 66. NAME OF COUNTRY | |
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| 67. NAME OF DEPARTMENT | | 68. NAME OF DEPARTMENT | |
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| Vital Statistics | | Vital Statistics | |
| 71. NAME OF OFFICE | | 72. NAME OF OFFICE | |
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| 75. NAME OF DISTRICT | | 76. NAME OF DISTRICT | |
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| 89. NAME OF COUNTRY | | 90. NAME OF COUNTRY | |
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| 95. NAME OF OFFICE | | 96. NAME OF OFFICE | |
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| 131. NAME OF STREET | | 132. NAME OF STREET | |
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| 309. NAME OF DIVISION | | 310. NAME OF DIVISION | |
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| Street | | Street | |
| 421. NAME OF CITY | | 422. NAME OF CITY | |
| Baltimore | | Baltimore | |
| 423 | | | |

VS. A15ME(S)
SM 9/55

OCT 2 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9484

CERTIFICATE OF DEATH

09460

Reg. Dist. No. 215

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington | |
| c. LENGTH OF STAY IN 1b 82 days | | d. STREET ADDRESS 3300 N. Columbus St. | |
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| 3. NAME OF DECEASED (Type or print) First Marion Middle Edwyn Last HARRISON | | 4. DATE OF DEATH Month September Day 30 Year 1956 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11 Dec. 1885 |
| 9. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired) | |
| 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Marion Drayton Harrison | | 14. MOTHER'S MAIDEN NAME Connelia Dennis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-I&II | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT (Son) Marion Edwyn Harrison (Same As #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 10 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from 10 June , 19 56 , to 30 Sept. , 19 56 , that I last saw the deceased alive on 30 Sept. , 19 56 , and that death occurred at 9:35 P. M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE R. G. Williams | | ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 10-2-56 | |
| PHYSICIAN'S NAME (Type) R. G. Williams, CDR, MC, USN | | U.S. Naval Hospital, Bethesda, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-4-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) Arlington, Virginia (State) _____ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE /GAWLER's & Sons Funeral Home, 1756 Penn. Ave., | | 24a. REC'D BY REGISTRAR DATE 10-1-56 | |
| 24b. REGISTRAR'S SIGNATURE Mary E. Parselly | | | |

U.S. GOVERNMENT PRINTING OFFICE

7-60896-1

OCT 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9485

CERTIFICATE OF DEATH

09461

Reg. Dist. No.

713

| | | | | | | | |
|--|------------------------------------|---|---|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville R.F.D. # 3 | | | | c. LENGTH OF STAY IN 1b Life | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, R.F. D. #3 (Cloverly) | | | | d. STREET ADDRESS Bryants Nursery Road | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bryants Nursery Road | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Richard Middle H. Last Hill, Sr. | | | | 4. DATE OF DEATH Month Sept. Day 7, Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 5, 1891 | 9. AGE (In years last birthday) 65 yrs. | IF UNDER 1 YEAR Months 65 | IF UNDER 24 HRS. Days 65 Hours 65 Min. 65 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Hill | | | | 14. MOTHER'S MAIDEN NAME Lucy Scott | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Carrie E. Hill (wife) | | Address Same as item 2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive rounded rosacea disease DUE TO (c) 10 yrs | | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan , 1952 to Sept , 1956, that I last saw the deceased alive on Sept 7 , 1956, and that death occurred at 12:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Md DATE SIGNED 9/10/56 | | | | | | | |
| ACTUAL SIGNATURE A.D. Bonifant | | | | M.D. Sandy Spring, Md | | | |
| PHYSICIAN'S NAME (Type) A.D. BONIFANT | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/11/56 | | 22c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cemetery | | 22d. LOCATION (City, town, or county) (State) Sandy Spring, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden | | | | ADDRESS Rockville, Maryland | | 24a. REC'D BY REGISTRAR SEP 13 1956 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Laurel Knight | | | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
 CERTIFICATE OF DEATH

| | | | | | |
|------------------------|--|--------------------|--|----------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES E. HARRIS | | JAN 13 1956 | | BALTIMORE, MD | |
| AGE | | SEX | | RACE | |
| 45 | | M | | W | |
| DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF RESIDENCE | |
| JAN 13 1911 | | BALTIMORE, MD | | BALTIMORE, MD | |
| OCCUPATION | | EDUCATION | | MARRIAGE | |
| FARMER | | HIGH SCHOOL | | MARRIED | |
| CAUSE OF DEATH | | MANNER OF DEATH | | CERTIFICATE OF DEATH | |
| HEART DISEASE | | NATURAL | | 1 | |
| IMMEDIATE CAUSE | | INTERMEDIATE CAUSE | | FUNDAMENTAL CAUSE | |
| CORONARY THROMBOSIS | | HYPERTENSION | | ARTERIOSCLEROSIS | |
| FURTHER HISTORY | | PREVIOUS ILLNESS | | TREATMENT | |
| NONE | | NONE | | NONE | |
| SIGNATURE OF PHYSICIAN | | DATE | | PLACE | |
| JAMES E. HARRIS | | JAN 13 1956 | | BALTIMORE, MD | |
| SIGNATURE OF REGISTRAR | | DATE | | PLACE | |
| JAMES E. HARRIS | | JAN 13 1956 | | BALTIMORE, MD | |

RECEIVED
 SEP 13 1956
 BUREAU V. 2

9417

CERTIFICATE OF DEATH

09462

Reg. Dist. No. 223

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> | |
| c. LENGTH OF STAY IN 1b <u>13 YRS</u> | | d. STREET ADDRESS <u>6711 ALLEGHENY AVE.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6711 ALLEGHENY AVE</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ESTHER MYRTLE HOLLOWAY</u> | | 4. DATE OF DEATH Month Day Year <u>SEPT. 9 1956</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN 25, 1894</u> |
| 9. AGE (In years last birthday) <u>62 yrs.</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>STANTON, ILL.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>THOMAS S. DRIPPS</u> | | 14. MOTHER'S MAIDEN NAME <u>LUCY SMITH</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>495-22-5308</u> | |
| 17. INFORMANT <u>KEITH HOLLOWAY</u> | | Address <u>TAKOMA PARK, 6711 ALLEGHENY AVE.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X Congestive Heart Failure</u> DUE TO (b) <u>Rheumatic Heart Disease</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Air embolism of liver</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb 21, 1950</u> to <u>Sept 8, 1956</u> that I last saw the deceased alive on <u>Sept 8, 1956</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Philip C. Jones</u> M.D. | | ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive Silver Spring Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>PHILIP E. JONES</u> | | DATE SIGNED <u>9-9-56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>SEPT. 13, 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. [illegible]</u> ADDRESS <u>TAKOMA PARK D.C. 254 CARROLL ST. N.W.</u> | | 24a. REC'D BY REGISTRAR DATE <u>9/11/56</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>[illegible]</u> | | | |

CERTIFICATE OF DEATH

Reg. Dist. No.

BUREAU V. S.

SEP 13 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09463

9486 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film G204 9-28-56 et

Reg. Dist. No.

214

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b <u>DOA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Hills</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>969 Salem Road</u> | | | | d. STREET ADDRESS <u>4806 Rockford DRIVE</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Grover Cleveland Hudson</u> | | | | 4. DATE OF DEATH Month Day Year <u>Sept 18, 1956</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb 8, 1900</u> | |
| 9. AGE (In years to birthday) <u>55</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Upholsterer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Upholster</u> | | 11. BIRTHPLACE (State or foreign country) <u>N. C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | |
| 13. FATHER'S NAME <u>William P. Hudson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>577-28-7016</u> | | 17. INFORMANT <u>William P. Hudson</u> Address <u>Landover Hill, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed.</u> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9/24/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Maryland.</u> | | | | ADDRESS | | 24a. REC'D BY REGISTRAR <u>SEP 24 1956</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u> | | | |

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RECEIVED

SEP 24 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9418

CERTIFICATE OF DEATH

09464

Reg. Dist. No. 223

| | | | | | | | |
|---|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>19 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u> | | | | d. STREET ADDRESS <u>1005 Memorial Dr.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>EMILY</u> Last <u>Hummer</u> | | | | 4. DATE OF DEATH Month <u>9</u> Day <u>1</u> Year <u>1956</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-12-70</u> | | 9. AGE (In years last birthday) <u>86</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>American</u> | |
| 13. FATHER'S NAME <u>James Lucas</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Keziah Mendenhall</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, if, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Chart</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emaciation & malnutrition</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Intestinal obstruction</u> DUE TO (c) <u>Carcinomatosis of bowel & stomach from ovary</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Aug 15</u> , 19 <u>56</u> , to <u>Sept. 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 31</u> , 19 <u>56</u> , and that death occurred at <u>6:40</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8700 Coleridge Rd. Silver Spring Md.</u> DATE SIGNED <u> </u> | | | | | | | |
| ACTUAL SIGNATURE <u>Wilfred W. Eastman</u> | | | | M.D. <u>8700 Coleridge Rd. Silver Spring Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>WILFRED W. EASTMAN</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit Burial Sept 4, 1956</u> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY <u> </u> | | 22d. LOCATION (City, town, or county) (State) <u>Hartford City, Indiana</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> | | | | ADDRESS <u>254 Carroll Ave NW DC</u> | | 24a. REC'D BY REGISTRAR DATE <u>9/4/56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>J. Arthur Walters</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. B.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 09465 | | |
|---|--|---------------------------------|--|---|---|--|--|--|---|---|--|--|
| 9487 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. 216 | | |
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | | c. LENGTH OF STAY IN 1b | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5526 Dorsey Lane</u> | | | | | d. STREET ADDRESS <u>5526 Dorsey Lane</u> | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>Rudolph</u> Middle <u>Wesley</u> Last <u>Johnson</u> | | | | | 4. DATE OF DEATH Month <u>9</u> Day <u>5</u> Year <u>56</u> | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Col.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) yrs. <u>1</u> Months <u>25</u> Days <u>25</u> | | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>Wesley Johnson</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Dorsey</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>[If yes, give war or dates of service]</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to vomitus</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Upper Respiratory Infection</u> (c) <u>Upper Respiratory Infection</u> DUE TO (c) <u>Upper Respiratory Infection</u> cause lost. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed.</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Brodcha</u> | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | DATE SIGNED | | |
| EXAMINER'S NAME (Type) <u>Frank J. Brodcha</u> | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | | 22b. DATE THEREOF <u>9/6/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>A. L. Anacoden</u> | | | | | ADDRESS <u>Rockville, Md.</u> | | 24a. REC'D BY REGISTRAR <u>9-7-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u> | | | |

2074 253 XV2

SEP 11 1956

RECEIVED

| | | | |
|--|-------------------------------------|--|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Transit | 22b. DATE THEREOF 9/20/56 | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) Orlando, Florida |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland | | 24a. REC'D BY REGISTRAR DATE 9-22-56 | 24b. REGISTRAR'S SIGNATURE <i>Bessie M. Horn</i> |

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

| | | | | | | | |
|-----------------------------------|--|------------------------|--|-----------------------------------|--|-------------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | |
| George Earl | | Male | | White | | March 1, 1921 | |
| Place of Birth | | Race | | Color | | Date of Death | |
| The Lincoln Center, Bethesda, Md. | | White | | White | | March 1, 1956 | |
| Cause of Death | | Manner of Death | | Place of Death | | Date of Death | |
| Heart Disease | | Natural | | The Lincoln Center, Bethesda, Md. | | March 1, 1956 | |
| Physician's Signature | | Signature of Informant | | Signature of Registrar | | Signature of Medical Examiner | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | |

BUREAU V. A.

SEP 25 1956

RECEIVED

Robert A. Humphrey-Bethesda, Md.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09467

9489 CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | | | | | |
|---|----------------------------------|--|--------------------------------------|---|--------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH Montgomery | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Montgomery | | MARYLAND | | STATE Maryland | | COUNTY Montgomery | |
| CITY (If outside corporate limits, write RURAL and give nearest town) Wheaton | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) Wheaton | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 13011 Matey Road | | | | STREET ADDRESS (If rural give location) 13011 Matey Road | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) Pandora Kalla | | | | 4. DATE OF DEATH (Month) (Day) (Year) Sept. 24, 19 56 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed | 8. DATE OF BIRTH 8/14/1886 | 9. AGE last birthday 70 yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Athens, Greece | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME -- Valakos | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT & ADDRESS 13011 Matey Road Mrs. P.A. Keller-Wheaton, Md. | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 584X IMMEDIATE CAUSE Cholera due to Common Duct Obstruction | | | | | | 4 days | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO | | | | | | 3 years | |
| STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Arteriosclerotic Heart Disease Emphysema and Chronic Bronchitis | | | | | | 10 years | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Sept 1, 1956 , to Sept 24, 1956 , that I last saw the deceased alive on Sept 24, 1956 , and that death occurred at 9:35 AM , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE John J. Curry M.D. | | | | ADDRESS (Street, city, town, state) M.D. 11301 Georgia Ave Silver Spring | | DATE SIGNED 9/24/56 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 9/27/56 | | NAME OF CEMETERY OR CREMATORY Washington National | | LOCATION (city, town, or county) Prince Georges Co., Md. | |
| 24. REC'D BY REGISTRAR 9/26/56 | | REGISTRAR'S SIGNATURE Francis Potter | | 25. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., | | ADDRESS 2901 14th St., N.W. Washington 9, D.C. | |

CERTIFICATE OF DEATH

Form No. 100-10

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH.

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

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DATE OF DEATH

BUREAU V. S.

SEP 28 1956

RECEIVED

INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9490
CERTIFICATE OF DEATH

09468
 215

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Alexandria | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 24 Days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria | | | | d. STREET ADDRESS 3834 Seminary Road | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First Walter Middle (NAME) Last KARIG | | 4. DATE OF DEATH | | Month Sept. Day 30 Year 19 56 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 13 Nov. 1898 | 9. AGE (In years last birthday) 57 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marinet | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired) | | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Martin Karig | | | | 14. MOTHER'S MAIDEN NAME Elise Ellis | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas with metastasis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anterior sclerotic Hunt Disease, Pulmonary Infection | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6 Sept. , 19 56 to 30 Sept. , 19 56 , that I last saw the deceased alive on 30 Sept. , 19 56 , and that death occurred at 8:40 A. M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE A. J. Cappellitti | | | | ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 10-1-56 | | | |
| PHYSICIAN'S NAME (Type) A. J. CAPPELLITTI, LCDR, MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. 10-1-56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-4-56 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons Joseph Gawler's & Sons, 1756 Penn. Ave., Wash. D.C. | | | | 24a. REC'D BY REGISTRAR DATE 10-1-56 | | 24b. REGISTRAR'S SIGNATURE Mary E. Cassell | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9491

CERTIFICATE OF DEATH

09469

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING | | c. LENGTH OF STAY IN 1b 5 months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 801 COPLEY LANE | | e. STREET ADDRESS 5707 38th AVENUE | |
| 3. NAME OF DECEASED (Type or print) First EMMA Middle EVELYN Last KENNEDY | | 4. DATE OF DEATH Month SEPT. Day 20 Year 19 56 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH SEPT. 7, 1886 |
| 9. AGE (In years last birthday) yrs. 70 | | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - retired | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME FLETCHER GREEN | | 14. MOTHER'S MAIDEN NAME EMMA E. HIGGINS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT Address Mr. David G. Kennedy, 10,612 Ordway Drive Silver Spring, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apoplexy, hemorrhagic 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) 8 yrs | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July , 19 56 , to Sept , 19 56 , that I last saw the deceased alive on Sept 20 , 19 56 , and that death occurred at 3:40 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE A. D. Bonifant | | ADDRESS (Street, city or town, state) DATE SIGNED Silver Spring, Md, 9/20/56 | |
| PHYSICIAN'S NAME (Type) A. D. BONIFANT | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 9/22/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY | | 22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey | | ADDRESS SILVER SPRING, MD. | |
| 24a. REC'D BY REGISTRAR DATE 9/22/56 | | 24b. REGISTRAR'S SIGNATURE Frances Tatter | |

10

SEP 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9492

CERTIFICATE OF DEATH

09470

Reg. Dist. No. 276

| | | | |
|---|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u> | | d. STREET ADDRESS <u>3610-38th St. N.W.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Henry Kindel</u> | | 4. DATE OF DEATH Month Day Year <u>Sept. 18 1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 8 1877</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Director of American Red Cross</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Martinsburg, W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>George Kindel</u> | | 14. MOTHER'S MAIDEN NAME <u>Rachel McClure</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>491x</u> | |
| 17. INFORMANT <u>DeWitt E. DeLawter</u> | | Address <u>8025 Aberdeen Rd. Bethesda 14 Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>491x</u> DUE TO (c) <u>vascular myocardiosis, Bronchial Cath</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>vascular myocardiosis, Bronchial Cath</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept. 11, 1956</u> , to <u>Sept. 18, 1956</u> , that I last saw the deceased alive on <u>Sept. 18, 1956</u> , and that death occurred at <u>7:40 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>DeWitt E. DeLawter</u> | | ADDRESS (Street, city or town, state) <u>8025 Aberdeen Rd. Bethesda 14 Md</u> | |
| DATE SIGNED <u>9/18/56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>DeWitt E. DeLawter</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>SEPT. 21, 1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL MUSEUM</u> | | 22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William L. Finkle</u> | | ADDRESS <u>510 C St. N.E.</u> | |
| 24a. REC'D BY REGISTRAR <u>9/22/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u> | |

RECEIVED

SEP 25 1956

BUREAU V. 2

WILL E. DAWLEY

WILL E. DAWLEY

SEP 18 1956

SEP 18 1956

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

9493

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|--|---|---|--------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 77 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | | | d. STREET ADDRESS 609 SW 5th Place | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Nicholas Middle (none) Last KORDICK | | | | 4. DATE OF DEATH Month September Day 20 Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-27-97 | | 9. AGE (In years last birthday) 59 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy | | 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Nicholas KORDICK | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW-I & II | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Nicholas KORDICK, Jr. (Same As #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma of prostate DUE TO (c) prostate | | | | INTERVAL BETWEEN ONSET AND DEATH 1 week 2 years, at least. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 5 July 19 56 , to 20 Sept. 19 56 , that I last saw the deceased alive on 20 Sept. 19 56 , and that death occurred at 12:00 noon M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Byron D. Casteel M.D. | | | | ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-21-56 | | | |
| PHYSICIAN'S NAME (Type) Byron D. Casteel, CAPT, MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-25-56 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey | | | | ADDRESS Bethesda, Md. | | 24a. REC'D BY REGISTRAR DATE 9-21-56 | |
| 24b. REGISTRAR'S SIGNATURE Mary E. Passell | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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• 117 - 60 51 217 98 - 6 -

(12)

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

2

BUREAU V. S.

SEP, 24, 1956

RECEIVED

9494

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> | | c. LENGTH OF STAY IN 1b <u>1 Mo. 4 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital, Bethesda, Maryland</u> | | d. STREET ADDRESS <u>4607 Glenbrook Parkway</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>(n)</u> Last <u>LAVELLE</u> | | 4. DATE OF DEATH Month <u>September</u> Day <u>11</u> Year <u>19 56</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>14 April, 1953</u> |
| 9. AGE (In years last birthday) <u>3 yrs.</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>United States</u> | |
| 13. FATHER'S NAME <u>Francis Michael LAVELLE</u> | | 14. MOTHER'S MAIDEN NAME <u>Grace MURPHY</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service) <u>None.</u> | | 16. SOCIAL SECURITY NO. <u>None.</u> | |
| 17. INFORMANT <u>Francis Michael LAVELLE</u> | | Address <u>4607 Glenbrook Parkway,</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive gastro-intestinal bleeding</u> <u>204.0</u> DUE TO <u>Acute lymphatic leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>14 months</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>7 Aug.</u> 19 <u>56</u> to <u>11 Sept.</u> 19 <u>56</u> , that I last saw the deceased alive on <u>11 Sept.</u> 19 <u>56</u> , and that death occurred at <u>8:40 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Thomas E. Cone Jr.</u> M.D. | | ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>9-12-56</u> | |
| PHYSICIAN'S NAME (Type) <u>THOMAS E. CONE, JR. CAPT, MC, USN</u> | | <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>9-12-56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9-14-56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Catherine's Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Moscow, Pennsylvania</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u> | | ADDRESS <u>Bethesda, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>9-12-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Mary E. Russell</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

RECEIVED
 SEP 13 1956
 BUREAU V. S.

| | | | |
|-----------------------|--|------------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| JAMES H. HARRIS | | JAN 15 1956 | |
| AGE | | SEX | |
| 65 | | M | |
| RACE | | EDUCATION | |
| W | | H | |
| MARRIAGE | | OCCUPATION | |
| M | | C | |
| PLACE OF BIRTH | | PLACE OF DEATH | |
| BALTIMORE, MD | | BALTIMORE, MD | |
| CAUSE OF DEATH | | MANNER OF DEATH | |
| CORONARY THROMBOSIS | | NATURAL | |
| IMMEDIATE CAUSE | | INTERMEDIATE CAUSE | |
| HEART FAILURE | | CORONARY THROMBOSIS | |
| PREVIOUS ILLNESS | | PREVIOUS SURGERY | |
| HYPERTENSION | | NONE | |
| TREATMENT | | HOSPITAL | |
| HOSPITAL | | PHYSICIAN | |
| J. H. HARRIS | | J. H. HARRIS | |
| SIGNATURE OF DECEASED | | SIGNATURE OF PHYSICIAN | |
| | | J. H. HARRIS | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| JAN 15 1956 | | JAN 15 1956 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filled with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9495

CERTIFICATE OF DEATH

09473

Reg. Dist. No. 216

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Alabama b. COUNTY Huntsville | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | c. LENGTH OF STAY IN 1b 43 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS 102 East 8th Street | |
| 3. NAME OF DECEASED (Type or print) First John Middle Clinton Last Ledford | | 4. DATE OF DEATH Month September Day 6 Year 19 56 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 15, 1923 |
| 9. AGE (In years last birthday) 33 yrs. | | IF UNDER 1 YEAR Months 6 Days 21 | IF UNDER 24 HRS. Hours 19 Min. 56 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor (Government) | | 10b. KIND OF BUSINESS OR INDUSTRY Redstone Arsenal | |
| 11. BIRTHPLACE (State or foreign country) Kentucky | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James B. Ledford | | 14. MOTHER'S MAIDEN NAME Louisa Eager | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT The Medical Record | | Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC DECOMPENSATION 410X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Mitral + Aortic Stenosis + Insufficiency DUE TO (c) RHEUMATIC HEART DISEASE | | | INTERVAL BETWEEN ONSET AND DEATH 19 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 25, 1956 , to September 6, 1956 , that I last saw the deceased alive on September 6, 1956 , and that death occurred at 9:55 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Duncan L. McCollester M.D. | | ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | |
| PHYSICIAN'S NAME (Type) Duncan L. McCollester, M.D. | | DATE SIGNED 9/6/56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Transit | | 22b. DATE THEREOF 9/6/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) Lancaster Kentucky | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robt. A. Pumphrey-7557 Wis. Ave. Bethesda, Md | | 24a. REC'D BY REGISTRAR 9-8-56 | |
| 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09474

9419

CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | d. STREET ADDRESS <u>2911 Newark St. N.W. Apt. 35</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Leroy</u> Middle <u>Gratt</u> Last <u>Leigh</u> | | 4. DATE OF DEATH Month <u>September</u> Day <u>5</u> Year <u>1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-17-71</u> |
| 9. AGE (In years last birthday) <u>85</u> yrs. | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor & Builder</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | |
| 11. BIRTHPLACE (State or foreign country) <u>Charlotte, N.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u> | |
| 13. FATHER'S NAME <u>James Leigh</u> | | 14. MOTHER'S MAIDEN NAME <u>Eliza Springs</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. _____ | |
| 17. INFORMANT <u>Hospital Records & Mrs. Irving Abramson</u> | | Address _____ | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease with</u> DUE TO <u>Paroxysmal Fibrillation</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left femur - Senility</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>June 8, 1953</u> , to <u>Sept 5, 1956</u> , that I last saw the deceased alive on <u>Sept 5, 1956</u> , and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Philip C. Jones</u> M.D. <u>918 Ellsworth Drive</u> <u>9-6-56</u> PHYSICIAN'S NAME (Type) <u>Silver Spring, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 22b. DATE THEREOF <u>9/8/56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) <u>Suitland, Md.</u> (State) _____ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The L. A. Nemes Co</u> ADDRESS <u>2901-14th St. Ave</u> | | 24a. REC'D BY REGISTRAR <u>9/8/56</u> DATE _____ | |
| 24b. REGISTRAR'S SIGNATURE <u>J. Edgar Dodd</u> | | | |

RECEIVED

SEP 10 1956

BUREAU 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09475

9496

CERTIFICATE OF DEATH

Reg. Dist. No. 276

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Georgia</u> b. COUNTY <u>Terrell</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 240 Rockville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dawson</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverly Sanitarium</u> | | | | d. STREET ADDRESS <u>49X-3</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Georgia Emma LEWIS</u> | | | | 4. DATE OF DEATH Month Day Year <u>Sept. 14, 1956</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb. 27, 1861</u> | |
| 9. AGE (In years last birthday) <u>95</u> yrs. | | IF UNDER 1 YEAR Months <u>6</u> Days <u>17</u> | | IF UNDER 24 HRS. Hours <u>17</u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | | 11. BIRTHPLACE (State or foreign country) <u>Louisiana</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Samuel Harrison</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Liza Wooley</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Mrs. J.E. Morris Dawson, Georgia</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Cerebrovascular accident</u> DUE TO (c) <u>Cerebral arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Undet.</u> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>6-26-56</u> 19 <u>9-14-56</u> to <u>9-12-56</u> 19 <u>56</u> and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>George A. Gray, Jr.</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>104 Cherry Chase Drive, Maryland</u> | | | |
| PHYSICIAN'S NAME (Type) <u>George A. Gray, Jr.</u> | | | | DATE SIGNED <u>9/14/56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u> | | 22b. DATE THEREOF <u>9-17-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>North Troy Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Orleans County, Vermont.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> | | | | ADDRESS <u>Bethesda, Maryland</u> | | 24a. REC'D BY REGISTRAR DATE <u>9-17-56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | | | |

9545

RECEIVED
SEP 19 1955

09476

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery County | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If resident before admission) o. STATE Washington | | b. COUNTY D.C. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | | c. LENGTH OF STAY IN 1b 6/9/56-9/8/56 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. | | 47X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedarcroft Sanitarium & Hospital | | | | d. STREET ADDRESS 1459 Chapin St. N. W. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Kattie | | First M. | | Middle Lewis | | Last September 8 1956 | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 18, 1866 | |
| 9. AGE (In years last birthday) yrs. 90 | | IF UNDER 1 YEAR Months 1 Days 20 | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Miami, Missouri | | 12. CITIZEN OF WHAT COUNTRY? America | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Sanitarium records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile debility DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH Indefinite Gradual | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/9 , 19 56 , to 9/8 , 19 56 , that I last saw the deceased alive on 9/7 , 19 56 , and that death occurred at 8:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cedarcroft San. & Hosp. Rt. 2 Columbia Road Silver Spring, Md. DATE SIGNED Sept. 8, 1956 | | ACTUAL SIGNATURE Alvin J. Kistler M.D. | | | | | |
| PHYSICIAN'S NAME (Type) Alvin J. Kistler, M. D. | | | | | | | |
| 22a. REMOVAL (Specify) 9/8/56 | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY Pleasant View Cemetery | | 22d. LOCATION (City, town, or county) (State) Camp Point, Ill. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co., 2901 14th St. N.W. | | ADDRESS Wash, D.C. | | 24a. REC'D BY REGISTRAR DATE 9/11/56 | | 24b. REGISTRAR'S SIGNATURE Francis Potter | |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09477

9498

CERTIFICATE OF DEATH

Reg. Dist. No. 211

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Browningsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Browningsville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Monrovia | | d. STREET ADDRESS R.F.D. Monrovia e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle L. Last Linthicum | | 4. DATE OF DEATH Month Sept. Day 6 Year 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 18, 1866 |
| 9. AGE (In years last birthday) 90 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Browningsville, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joshua H. Purdum | | 14. MOTHER'S MAIDEN NAME Martha Browning | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs Ivan T. Lawson, Ijamsville, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 4.20.1 DUE TO Arteriosclerosis coronary vessels years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Arteriosclerosis, generalized years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old cerebro-vascular accident, hemiplegia, cerebral art.scl. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept. 1 , 19 56 , to Sept. 6 , 19 56 , that I last saw the deceased alive on Sept. 6 , 19 56 , and that death occurred at 1 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boyer Clinic, DATE SIGNED 9/7/56 ACTUAL SIGNATURE Gilcin F. Meadors, Jr. M.D. PHYSICIAN'S NAME (Type) Gilcin F. Meadors, Jr., M.D. Damascus, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept. 8, 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY Bethesda Meth. | | 22d. LOCATION (City, town, or county) (State) Browningsville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth ADDRESS Damascus, Md. | | 24a. REC'D BY REGISTRAR DATE Sept 7/56 24b. REGISTRAR'S SIGNATURE Deella W. Burdette | |

CERTIFICATE OF DEATH

Form 10-1-57

| | | | | | |
|--|--|---|--|--|--|
| Name of Deceased Brown, Joseph H. | | Sex Male | | Age 38 | |
| Date of Death Sept. 18, 1956 | | Place of Death Home | | City Baltimore, Md. | |
| Cause of Death Myocardial Infarction | | Contributing Causes Hypertension | | Manner of Death Natural | |
| Physician's Signature [Signature] | | Medical Examiner's Signature [Signature] | | Registrar's Signature [Signature] | |
| Date of Report Sept. 20, 1956 | | Place of Report Home | | City Baltimore, Md. | |
| Name of Informant Mrs. Ivan T. Lawson | | Relationship Wife | | Address [Address] | |
| Signature of Informant [Signature] | | Signature of Physician [Signature] | | Signature of Medical Examiner [Signature] | |
| Date of Signature Sept. 20, 1956 | | Place of Signature Home | | City Baltimore, Md. | |

RECEIVED
SEP 10 1956
BUREAU V. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9420
CERTIFICATE OF DEATH

09478

Reg. Dist. No. 223

| | | | |
|---|---------------------------|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park 12, Md.</i> | | c. LENGTH OF STAY IN 1b <i>7-19-56-9/27/56</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Wash. San Hosp.</i> | | d. STREET ADDRESS <i>867 Van Buren St. N.W.</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Joseph Younger Longest</i> | | 4. DATE OF DEATH <i>Sept. 27 1956</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>8-9-80</i> |
| 9. AGE (In years last birthday) <i>76</i> yrs. | | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired steward</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Va</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Barton Longest, Va.</i> | | 14. MOTHER'S MAIDEN NAME <i>Lucy C. Halbert Va.</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>--</i> | |
| 17. INFORMANT <i>Hospital Records</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Suppurative Parotitis</i> DUE TO <i>260X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes Mellitus</i> DUE TO (c) <i>Arteriosclerosis</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Nephritis + Uremic State</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Sept 27, 1956</i> to <i>Sept 27, 1956</i> ; that I last saw the deceased alive on <i>Sept 27, 1956</i> , and that death occurred at <i>10:20 PM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Robert A Hare</i> M.D. | | ADDRESS (Street, city or town, state) <i>Takoma Park, Md.</i> DATE SIGNED <i>9/27/56</i> | |
| PHYSICIAN'S NAME (Type) <i>Robert A Hare</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>10/1/56</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>She S. H. Hines Co.</i> ADDRESS <i>2901-14th St</i> | | 24a. REC'D BY REGISTRAR DATE <i>9/19/56</i> | |
| 24b. REGISTRAR'S SIGNATURE <i>J. Wilson Rodd</i> | | | |

WASHINGTON D.C.

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9499 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09479

Reg. Dist. No.

216

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> | | | |
| c. LENGTH OF STAY IN 1b <u>13 years</u> | | | | d. STREET ADDRESS <u>R.F.D. 3</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. 3</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>L.</u> Last <u>Lowe, Sr.</u> | | | | 4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>1956</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-25-90</u> | |
| 9. AGE (in years last birthday) <u>65 yrs.</u> | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>? LOWE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>World War I</u> | | | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT <u>Arthur L. Lowe, Jr.</u> Address <u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock - traumatic</u> 928.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Crushed chest + ruptured liver</u> (c) <u> </u> DUE TO (c) <u> </u> DUE TO (c) <u> </u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>mangled & stomped by a bull</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> o. m. <u>pm</u> <u>9/12/56</u> | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home-farm</u> | | 20f. (City or town) (County) (State) <u>Gaithersburg Montgomery Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart, M. D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9/15/1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gaudin Sons</u> | | | | ADDRESS <u>1756 Pa. Ave., N.W. DC</u> | | 24a. REC'D BY REGISTRAR DATE <u>9-15-56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------|--|-------------|--|----------------|--|-----------------|--|------------------------|--|----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | | PLACE OF DEATH | |
| LOVE | | 18 | | F | | W | | 1956 | | BALTIMORE | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | SIGNATURE OF EXAMINER | | DATE | |
| BALTIMORE | | HOUSEWIFE | | HEART DISEASE | | NATURAL | | J. H. SMITH | | 1956 | |
| FATHER | | MOTHER | | BIRTH | | DEATH | | SIGNATURE OF REGISTRAR | | DATE | |
| J. H. SMITH | | J. H. SMITH | | J. H. SMITH | | J. H. SMITH | | J. H. SMITH | | J. H. SMITH | |

UNIT NO. 18

LOVE

1956

BUREAU V. S.

SEP 18 1956

RECEIVED

1956 BALTIMORE, M. D.
J. H. SMITH
BALTIMORE, M. D.
J. H. SMITH
BALTIMORE, M. D.
J. H. SMITH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9421 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09480

Reg. Dist. No. 223

| | | | | | | | |
|---|---|--|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u> | | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8323 Haddon Drive</u> | | | | d. STREET ADDRESS <u>4 Noyes Drive</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Horace</u> Middle <u>Hill</u> Last <u>Marple</u> | | | | 4. DATE OF DEATH Month <u>9/22/56</u> Day <u>19</u> Year <u>19</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAR 12, 1916</u> | 9. AGE (In years last birthday) <u>40</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dentist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>GEN. DENTISTRY</u> | | 11. BIRTHPLACE (State or foreign country) <u>W. VA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>HORACE H. MARPLE, SR.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARGARET E. GORMAN.</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>MRS. ANGELINE C. MARPLE, 4 NOYES DRIVE, SS. MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED <u>9/22/56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>Sept 26, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASH N. CEM.</u> | | 22d. LOCATION (City, town, or county) <u>RIGGS RD. HATTISVILLE CO. MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> | | | | ADDRESS <u>254 CARROLL ST. N.W. P.C.</u> | | 24a. REC'D. BY REGISTRAR | |
| 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | DATE <u>9/24/56</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To burial, cremation, or removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9500

CERTIFICATE OF DEATH

Reg. Dist. No. 09481 7-17

| | | | | | | | |
|---|--|-------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | | | c. LENGTH OF STAY IN 1b 16 hours | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital | | | | d. STREET ADDRESS General Delivery | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Baby Boy Middle Martin Last Martin | | | | 4. DATE OF DEATH Month September Day 10 Year 56 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9/10/56 | |
| 9. AGE (In years last birthday) yrs. | | IF UNDER 1 YEAR Months | | IF UNDER 24 HRS. Days | | Hours | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Richard Edward Martin | | | | 14. MOTHER'S MAIDEN NAME Edith Lucille Dove | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mother | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO atelectasis, possible aspiration pneumonia - from chokes. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) prematurity. DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 9/10 , 19 56 , to 9/10 , 19 56 , that I last saw the deceased alive on 9/10 , 19 56 , and that death occurred at 10:00 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE W. A. Linthicum | | | | ADDRESS (Street, city or town, state) Rockville, Md. | | | |
| DATE SIGNED 9/10/56 | | | | 110 S. West St. | | | |
| PHYSICIAN'S NAME (Type) W. A. Linthicum, M. D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/12/56 | | 22c. NAME OF CEMETERY OR CREMATORY Lincoln Park, | | 22d. LOCATION (City, town, or county) (State) Rockville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Shorde | | | | ADDRESS Rockville, Md. | | 24a. REC'D BY REGISTRAR 7-13-56 | |
| 24b. REGISTRAR'S SIGNATURE Guinde B Fowler | | | | | | | |

2073193XV2

CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|---|--|
| 1. NAME OF DECEASED <i>John Doe</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>45</i> | |
| 4. DATE OF DEATH <i>Sept 15, 1956</i> | | 5. TIME OF DEATH <i>10:30 AM</i> | | 6. PLACE OF DEATH <i>Home</i> | |
| 7. CAUSE OF DEATH <i>Myocardial Infarction</i> | | 8. MANNER OF DEATH <i>Natural</i> | | 9. PLACE OF BIRTH <i>Boston, Mass.</i> | |
| 10. DATE OF BIRTH <i>Aug 15, 1911</i> | | 11. SEX OF BIRTH <i>Male</i> | | 12. AGE AT BIRTH <i>45</i> | |
| 13. OCCUPATION <i>Engineer</i> | | 14. EDUCATION <i>High School</i> | | 15. RELIGION <i>Protestant</i> | |
| 16. MARITAL STATUS <i>Married</i> | | 17. NAME OF SPOUSE <i>Jane Doe</i> | | 18. DATE OF MARRIAGE <i>May 10, 1935</i> | |
| 19. NAME OF PHYSICIAN <i>Dr. J. Smith</i> | | 20. NAME OF HOSPITAL <i>St. Mary's</i> | | 21. NAME OF NURSE <i>Mrs. Brown</i> | |
| 22. NAME OF FUNERAL HOME <i>John's Funeral Home</i> | | 23. NAME OF BURIAL PLACE <i>St. Mary's Cemetery</i> | | 24. NAME OF MINISTER <i>Rev. Mr. Jones</i> | |
| 25. NAME OF CORONER <i>Mr. White</i> | | 26. NAME OF JURY <i>None</i> | | 27. NAME OF JUDGE <i>None</i> | |
| 28. NAME OF STATE ATTORNEY <i>None</i> | | 29. NAME OF DISTRICT ATTORNEY <i>None</i> | | 30. NAME OF COUNTY ATTORNEY <i>None</i> | |
| 31. NAME OF CITY ATTORNEY <i>None</i> | | 32. NAME OF TOWN ATTORNEY <i>None</i> | | 33. NAME OF VILLAGE ATTORNEY <i>None</i> | |
| 34. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 35. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 36. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 37. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 38. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 39. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 40. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 41. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 42. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 43. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 44. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 45. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 46. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 47. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 48. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 49. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 50. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 51. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 52. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 53. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 54. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 55. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 56. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 57. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 58. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 59. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 60. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 61. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 62. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 63. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 64. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 65. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 66. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 67. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 68. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 69. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 70. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 71. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 72. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 73. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 74. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 75. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 76. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 77. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 78. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 79. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 80. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 81. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 82. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 83. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 84. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 85. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 86. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 87. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 88. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 89. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 90. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 91. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 92. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 93. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 94. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 95. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 96. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 97. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 98. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 99. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |
| 100. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 101. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | | 102. NAME OF PLANNED PARCEL ATTORNEY <i>None</i> | |

BUREAU V. S.

SEP 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9501

CERTIFICATE OF DEATH

09482

Reg. Dist. No. 216

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kentucky b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 11 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS --- | | | |
| 3. NAME OF DECEASED (Type or print) First Bernice Middle Ann Last Martin | | | | 4. DATE OF DEATH Month September Day 27 , Year 19 56 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 17, 1938 | |
| 9. AGE (In years last birthday) 18 yrs. | | IF UNDER 1 year Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Kentucky | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Burnett Martin | | | | 14. MOTHER'S MAIDEN NAME Gladys Strunk | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X Ventricular fibrillation DUE TO during surgery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mitral incompetence, RHD. (c) 10 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yrs. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from September 16, 19 56 to September 27, 19 56 , that I last saw the deceased alive on September 27, 19 56 , and that death occurred at 11:32 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE John Ross, Jr. | | | | DATE SIGNED 9/27/56 | | | |
| PHYSICIAN'S NAME (Type) John Ross, Jr., M. D. | | | | ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL Removal | | 22b. DATE THEREOF 9/27/56 | | 22c. NAME OF CEMETERY OR CREMATORY --- | | 22d. LOCATION (City, town, or county) (State) Hazard, Kentucky | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company | | | | 24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C. | | 24b. REGISTRAR'S SIGNATURE 9/28/56 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9502

CERTIFICATE OF DEATH

09483

Reg. Dist. No.

216

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, 14, Maryland | | c. LENGTH OF STAY IN 1b 4 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, 14, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Clara Anne Martin | | 4. DATE OF DEATH Month Day Year September 18, 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 16, 1903 |
| 9. AGE (In years last birthday) 53 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistical Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Government | |
| 11. BIRTHPLACE (State or foreign country) South Dakota | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James McCarthy | | 14. MOTHER'S MAIDEN NAME Clara Myers | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 473-03-3785 | |
| 17. INFORMANT The Medical Record | | Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidervial Carcinoma of Cervix DUE TO 171x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic carcinoma - uterus? DUE TO (c) small bowel - mesaria | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from September 14, 1956 , to September 18, 1956 , that I last saw the deceased alive on September 18, 1956 , and that death occurred at 10.00AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE David G. Nathan M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center National Institutes of Health Bethesda 14, Maryland | |
| PHYSICIAN'S NAME (Type) David G. Nathan, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Sept 20-56 Cedar Hill Cemetery | | 22c. NAME OF CEMETERY OR CREMATORY Sunderland | |
| 22d. LOCATION (City, town, or county) (State) and | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros 1461-44th Ave SE | | 24a. REC'D BY REGISTRAR DATE 21 1956 | |
| 24b. REGISTRAR'S SIGNATURE Bessie Thompson | | | |

38, 10/10-10/11, 10/12, 10/13, 10/14, 10/15, 10/16, 10/17, 10/18, 10/19, 10/20, 10/21, 10/22, 10/23, 10/24, 10/25, 10/26, 10/27, 10/28, 10/29, 10/30, 10/31, 11/1, 11/2, 11/3, 11/4, 11/5, 11/6, 11/7, 11/8, 11/9, 11/10, 11/11, 11/12, 11/13, 11/14, 11/15, 11/16, 11/17, 11/18, 11/19, 11/20, 11/21, 11/22, 11/23, 11/24, 11/25, 11/26, 11/27, 11/28, 11/29, 11/30, 12/1, 12/2, 12/3, 12/4, 12/5, 12/6, 12/7, 12/8, 12/9, 12/10, 12/11, 12/12, 12/13, 12/14, 12/15, 12/16, 12/17, 12/18, 12/19, 12/20, 12/21, 12/22, 12/23, 12/24, 12/25, 12/26, 12/27, 12/28, 12/29, 12/30, 12/31, 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9422

CERTIFICATE OF DEATH

09484

Reg. Dist. No.

223

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>4 1/2</u> days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Karolina Agnes Masaryk</u> | | 4. DATE OF DEATH Month Day Year <u>September 14 19 56</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-24-75</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 11. BIRTHPLACE (State or foreign country) <u>Czek.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | |
| 13. FATHER'S NAME <u>Stephen Baranek</u> | | 14. MOTHER'S MAIDEN NAME <u>Sophie Suchonik</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u> | | 16. SOCIAL SECURITY NO. ----- | |
| 17. INFORMANT <u>Hospital Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331x</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Cerebral Hemorrhage</u> (c) DUE TO <u>Hypertension</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 days</u> <u>8 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan 48</u> , 19 <u>48</u> , to <u>Sept 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 13</u> , 19 <u>56</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John N. Andrews</u> | | ADDRESS (Street, city or town, state) <u>9601 Colesville Rd Silver Spring Md.</u> | |
| DATE SIGNED <u>Sept 14-56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>John N. Andrews</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-17-56</u> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>mt. Olivet</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington DC</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Linnetty Naylor</u> | | ADDRESS <u>3831 - G.R. Avenue</u> | |
| 24a. REC'D BY REGISTRAR <u>SEP 17 1956</u> | | DATE | |
| 24b. REGISTRAR'S SIGNATURE <u>J. Nelson Saddy</u> | | | |

SEP 17 1956

BUREAU V.

RECEIVED

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. For a burial, cremation, or removal, TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9424 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Item 14, Film G204 10-2-56 et

99486-223
Reg. Dist. No.

| | | | |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7725 Carroll Ave | | d. STREET ADDRESS 7725 Carroll Ave | |
| 3. NAME OF DECEASED (Type or print) Saul First Matosky Middle Matosky Last | | 4. DATE OF DEATH Month 9/20/56 Day 19 Year | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/5/1903 |
| 9. AGE (In years last birthday) 53 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sgt. USA | | 10b. KIND OF BUSINESS OR INDUSTRY retired | |
| 11. BIRTHPLACE (State or foreign country) Pa. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Jacob Matosky | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Susie Matosky (wife) | | Address Same as Item 2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 9/21/56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF SEPT 24 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL CEMETERY | | 22d. LOCATION (City, town, or county) (State) ARLINGTON, ARL. CO. VA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE 254 CARROLL ST. N.W. D.C. | | 24a. REC'D BY REGISTRAR DATE 9/22/56 | |
| 24b. REGISTRAR'S SIGNATURE J. Wilson Dool | | | |

SEP 25 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 189487
 9425 CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | |
|--|---------------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> | |
| c. LENGTH OF STAY IN 1b <u>21 YRS</u> | | 17 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7401 BALTIMORE AVE.</u> | | d. STREET ADDRESS <u>7401 BALTIMORE AVE</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>MATILDA</u> Middle <u>S.</u> Last <u>MAY</u> | | 4. DATE OF DEATH Month <u>Sept</u> Day <u>30</u> Year <u>1956</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT. 23, 1860</u> |
| 9. AGE (In years last birthday) <u>95</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>SYRACUSE, N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>HENRY SIEFKER</u> | | 14. MOTHER'S MAIDEN NAME <u>WILHELMINA BECKER.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>FRANKLIN H. MAY</u> Address <u>7401 BALTIMORE AVE. TAKOMA PARK, MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bleeding both feet</u> <u>450.1</u> DUE TO (b) <u>Senile Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>15-year old.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April</u> , 19 <u>46</u> , to <u>30 Sept</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>28 Sept</u> , 19 <u>56</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>H. B. Queen</u> M.D. <u>7112 Willow Ave</u> | | DATE SIGNED <u>30 Sept 1956</u> | |
| PHYSICIAN'S NAME (Type) <u>H. B. QUEEN</u> | | <u>Takoma Park, MD</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>OCT. 3, 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>OAKWOOD CEMETERY</u> | 22d. LOCATION (City, town, or county) (State) <u>SYRACUSE, N.Y.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>TAKOMA PARK, DC 254 CARROLL ST. NW.</u> | | 24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>10/3/56</u> | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> |

BUREAU V. S.

OCT 8 1956

RECEIVED

9503

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|---|----------------------------------|---|---|---|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 2 mos. 10 days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | | | 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | | | d. STREET ADDRESS 2010 Maryland Ave., N.E. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Helen Middle Johnson Last MC CLAIN | | | | 4. DATE OF DEATH Month SEPTEMBER Day 7 Year 1956 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4 March 1916 | 9. AGE (In years last birthday) yrs. 40 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic Work | | 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Solomon Johnson | | | | 14. MOTHER'S MAIDEN NAME Rebecca Amaker | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT Address Clinton V. Mc Clain, (Son) Same As #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral metastatic carcinoma 170X DUE TO Carcinoma of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 mo 4 mo. | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 27 June , 19 56 , to 7 September , 19 56 , that I last saw the deceased alive on 7 Sept. , 19 56 , and that death occurred at 2:35 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William H. Howell M.D. | | | | ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. | | | |
| PHYSICIAN'S NAME (Type) William H. Howell, Jr. LCDR, MC, USN | | | | DATE SIGNED 9-7-56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-13-56 | | 22c. NAME OF CEMETERY OR CREMATORY Private Cemetery | | 22d. LOCATION (City, town, or county) (State) Blackville, South Carolina | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOFFMAN Funeral Home 611 "K" St., N.W. Washington | | | | ADDRESS D. C. | | 24a. REC'D BY REGISTRAR DATE 9-7-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

1956

| | | | |
|-----------------------------|--|----------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| JAMES EARL RAY | | APRIL 4, 1968 | |
| PLACE OF DEATH | | CITY | |
| MEMPHIS, TENNESSEE | | MEMPHIS, TENNESSEE | |
| AGE | | SEX | |
| 35 | | MALE | |
| RACE | | OCCUPATION | |
| WHITE | | ATTORNEY | |
| BIRTH DATE | | BIRTH PLACE | |
| JANUARY 10, 1933 | | ALBANY, MISSISSIPPI | |
| MARRIAGE DATE | | MARRIAGE PLACE | |
| MAY 1, 1955 | | MEMPHIS, TENNESSEE | |
| MOTHER'S NAME | | FATHER'S NAME | |
| LUCILLE E. RAY | | JAMES EARL RAY | |
| EDUCATION | | RELIGION | |
| HIGH SCHOOL | | METHODIST | |
| PREVIOUS ILLNESS | | CAUSE OF DEATH | |
| NONE | | HEART DISEASE | |
| MANNER OF DEATH | | CERTIFICATE NO. | |
| NATURAL | | 100-100000 | |
| PLACE OF BURIAL | | DATE OF BURIAL | |
| MEMPHIS, TENNESSEE | | APRIL 4, 1968 | |
| NAME OF FUNERAL HOME | | NAME OF MINISTER | |
| JAMES EARL RAY FUNERAL HOME | | JAMES EARL RAY | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | |
| JAMES EARL RAY | | JAMES EARL RAY | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| APRIL 4, 1968 | | APRIL 4, 1968 | |

BUREAU V. S.

SEP 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09480

9504 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|---|---|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b unknown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5717 Greenlawn Drive | | | | d. STREET ADDRESS 5717 Greenlawn Drive | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle EDWARD Last McCRACKEN | | | | 4. DATE OF DEATH Month September Day 11th Year 1956 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 22, 1885 | | 9. AGE (In years last birthday) 71 yrs. | IF UNDER 1 YEAR Months 0 Days 19 | IF UNDER 24 HRS. Hours 19 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Elevator Opr. US Govt. | | 11. BIRTHPLACE (State or foreign country) Washington County, Va. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Richard McCracken | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 225-30-5426 | | 17. INFORMANT James E. McCracken- Bethesda, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 wk |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | Sept. 11, 1956 | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9-14-56 | 22c. NAME OF CEMETERY OR CREMATORY Parklawn Cem | | 22d. LOCATION (City, town, or county) Montgomery | | (State) Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS Bethesda Md | | 24a. REC'D BY REGISTRAR 9-13-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Beattie M. Harrison | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|-------------------------------|--|------------------------------------|--|
| Name of Deceased | | John | |
| Sex | | Male | |
| Race | | White | |
| Date of Birth | | August 22, 1885 | |
| Place of Birth | | Washington County, Md. | |
| Residence | | Bethesda | |
| Occupation | | Unknown | |
| Cause of Death | | Coronary Occlusion | |
| Manner of Death | | Natural | |
| Signature of Physician | | James E. McCracken - Bethesda, Md. | |
| Signature of Medical Examiner | | Frank J. Paschke | |
| Date | | September 17, 1956 | |
| Place | | Bethesda | |
| Signature of Coroner | | Unknown | |
| Signature of Registrar | | Unknown | |

BUREAU T. 8

SEP. 17. 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09490

9426

CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | | | | | |
|--|---------------------------|--|---------------------------------|--|-----------------|--|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY — | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN & HOSP. | | | | d. STREET ADDRESS 7225 BLAIR RD., N.W. | | | |
| 3. NAME OF DECEASED (Type or print) NORMAN EUGENE McINDOO | | | | 4. DATE OF DEATH SEPT. 7, 1956 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-11-81 | 9. AGE (In years last birthday) 75 yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENTOMOLOGIST PHD (RET) US GOVT. PA. | | | | 10b. KIND OF BUSINESS OR INDUSTRY IND. | | 11. BIRTHPLACE (State or foreign country) IND. | |
| 13. FATHER'S NAME JACOB McINDOO | | | | 14. MOTHER'S MAIDEN NAME SARAH HALSTEAD | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | | | 17. INFORMANT EMMA P. McINDOO, 7225 BLAIR RD N.W. D.C. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Congestion Heart Failure DUE TO (b) Arterio-sclerosis DUE TO (c) Enlarged Heart | | | | INTERVAL BETWEEN ONSET AND DEATH 1 WK. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from Sept 1, 1956 to Sept 7, 1956 , that I last saw the deceased alive on Sept 7, 1956 , and that death occurred at 2:30 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE A. B. Little | | | | DATE SIGNED Sept 7, 1956 | | | |
| PHYSICIAN'S NAME (Type) A. B. LITTLE MD | | | | ADDRESS (Street, city or town, state) 2000 WASH. DC | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF SEPT. 10, 1956 | | 22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK SEMETERY | | 22d. LOCATION (City, town, or county) (State) WASHINGTON D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John R. Little | | | | 24a. REC'D BY REGISTRAR DATE 9/8/56 | | 24b. REGISTRAR'S SIGNATURE Emma P. McIndoo | |

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9505

CERTIFICATE OF DEATH

09491

Reg. Dist. No. 216

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE North Carolina b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b 69 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION The Clinical Center National Institutes of Health, Bethesda, Md. | | | | d. STREET ADDRESS 309 East Mulberry Street | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle Frank Last McInnis | | | | 4. DATE OF DEATH Month September Day 2 Year 19 56 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 28 May 1906 | |
| 9. AGE (In years last birthday) 50 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Professional | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 13. FATHER'S NAME John F. McInnis | | | | 14. MOTHER'S MAIDEN NAME Carrie S. Sellers | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 239-52-2401 | | 17. INFORMANT The Medical Record, Clinical Center National Institutes of Health, Bethesda 14, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190x Bronchial Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malignant Melanoma DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH Three 3 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 0 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from 25 June , 19 56 , to 2 September , 19 56 , that I last saw the deceased alive on 2 September , 19 56 , and that death occurred on 7.05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) National Institutes of Health, Bethesda 14, Maryland DATE SIGNED 9/2/56 | | | | | | | |
| ACTUAL SIGNATURE Thomas Waldmann | | | | PHYSICIAN'S NAME (Type) Thomas Waldmann, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/4/56 | | 22c. NAME OF CEMETERY OR CREMATORY Willow Dale Cemetery | | 22d. LOCATION (City, town, or county) (State) Goldsboro North Carolina | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Saunders Sons | | | | 24a. REC'D BY REGISTRAR 1738 Pennsylvania Ave NW, Washington, D.C. 20548 | | 24b. REGISTRAR'S SIGNATURE Beattie M. Thompson | |

1890

1890

BUREAU V. S.

SEP 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 201 9-26-56

9506

CERTIFICATE OF DEATH

Reg. Dist. No. 09492

| | | | | | | | |
|---|----------------------------------|--|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 14 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Amelia Middle Erminia Last MC MURRY | | | | 4. DATE OF DEATH Month September Day 21 Year 19 56 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 30 January 1913 | 9. AGE (In years last birthday) yrs. 43 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Joseph Cerco | | | | 14. MOTHER'S MAIDEN NAME Mary Yaselli | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Address Husband, Delmo MC MURRY (Same As #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic carcinoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH Indefinite | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | | | |
| 21. I certify that I attended the deceased from 7 Sept. , 19 56 , to 21 Sept. , 19 56 , that I last saw the deceased alive on 21 Sept. , 19 56 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE J. J. Horgan | | | | ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. | | | |
| DATE SIGNED 9-22-56 | | | | | | | |
| PHYSICIAN'S NAME (Type) J. T. Horgan, LT, MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-25-56 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home, 4th & Mass Ave. S.E., | | | | 24a. REC'D BY REGISTRAR DATE 9-22-56 | | 24b. REGISTRAR'S SIGNATURE Mary E. Yaselli | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
 CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|-------------------------------------|--|----------------------------------|--|---------------------------------------|--|------------------------------|--|----------------------------------|--|----------------------------------|--|
| NAME OF DECEASED JAMES H. HARRIS | | AGE 45 | | SEX Male | | RACE White | | DATE OF BIRTH 1910 | | PLACE OF BIRTH Baltimore, Md. | |
| MARRIAGE Married | | DATE OF MARRIAGE 1935 | | NAME OF SPOUSE Mary H. Harris | | DATE OF DEATH 1956 | | PLACE OF DEATH Baltimore, Md. | | CAUSE OF DEATH Heart Disease | |
| OCCUPATION Teacher | | EDUCATION High School | | RELIGION Roman Catholic | | MANNER OF DEATH Natural | | DURATION OF ILLNESS 2 weeks | | DATE OF INTERMENT 1956 | |
| PREVIOUS ILLNESS None | | DATE OF PREVIOUS ILLNESS None | | NAME OF PHYSICIAN Dr. J. H. Harris | | DATE OF CONSULTATION 1956 | | NAME OF HOSPITAL None | | DATE OF ADMISSION None | |
| DATE OF DEATH 1956 | | PLACE OF DEATH Baltimore, Md. | | CAUSE OF DEATH Heart Disease | | MANNER OF DEATH Natural | | DURATION OF ILLNESS 2 weeks | | DATE OF INTERMENT 1956 | |
| NAME OF DECEASED JAMES H. HARRIS | | AGE 45 | | SEX Male | | RACE White | | DATE OF BIRTH 1910 | | PLACE OF BIRTH Baltimore, Md. | |
| MARRIAGE Married | | DATE OF MARRIAGE 1935 | | NAME OF SPOUSE Mary H. Harris | | DATE OF DEATH 1956 | | PLACE OF DEATH Baltimore, Md. | | CAUSE OF DEATH Heart Disease | |
| OCCUPATION Teacher | | EDUCATION High School | | RELIGION Roman Catholic | | MANNER OF DEATH Natural | | DURATION OF ILLNESS 2 weeks | | DATE OF INTERMENT 1956 | |
| PREVIOUS ILLNESS None | | DATE OF PREVIOUS ILLNESS None | | NAME OF PHYSICIAN Dr. J. H. Harris | | DATE OF CONSULTATION 1956 | | NAME OF HOSPITAL None | | DATE OF ADMISSION None | |
| DATE OF DEATH 1956 | | PLACE OF DEATH Baltimore, Md. | | CAUSE OF DEATH Heart Disease | | MANNER OF DEATH Natural | | DURATION OF ILLNESS 2 weeks | | DATE OF INTERMENT 1956 | |

BUREAU V. S.

SEP 24 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

9507

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Minnesota b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 25 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grand Rapids | | 60 X - 3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland | | d. STREET ADDRESS Route 1, Box 266 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Frederick Louis METZENHUBER | | 4. DATE OF DEATH Month Day Year September 21 19 56 | |
| 5. SEX Male | 6. COLOR OR RACE Cauca | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-27-87 |
| 9. AGE (In years last birthday) 68 69 = yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy | 11. BIRTHPLACE (State or foreign country) Austria |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME Fred METZENHUBER | | 14. MOTHER'S MAIDEN NAME Mary WILKINS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I and WW II 578-50-0235 | |
| 17. INFORMANT Anton Steve METZENHUBER | | Address Route 1, Box 266 Grand Rapids, Minnesota | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Gastrointestinal Hemorrhage IMMEDIATE CAUSE (a) 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 578X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 27 August 19 56 , to 21 September 19 56 , that I last saw the deceased alive on 21 September 19 56 , and that death occurred at 11:55A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Gerald D. Shugoll M.D. | | ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-22-56 | |
| PHYSICIAN'S NAME (Type) G.I. SHUGOLL, LT, MC, USN | | U.S. Naval Hospital, Bethesda, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-26-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S NAME (Type) Pumphrey Funeral Home | | ADDRESS 7557 Wisconsin Ave. Bethesda, Maryland | |
| 24a. REC'D BY REGISTRAR DATE 9-22-56 | | 24b. REGISTRAR'S SIGNATURE Mary E. Carrelly | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9508

CERTIFICATE OF DEATH

09494

Reg. Dist. No. 216

| | | | |
|--|-----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | d. STREET ADDRESS <u>1933-11th Avenue Road</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>METZINGER</u> Last <u></u> | | 4. DATE OF DEATH Month <u>9</u> Day <u>5</u> Year <u>1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1906</u> <u>Aug. 16, 1906</u> |
| 9. AGE (In years last birthday) <u>50</u> yrs. | | IF UNDER 1 YEAR: Months <u>0</u> Days <u>19</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Frederick, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William Shane</u> | | 14. MOTHER'S MAIDEN NAME <u>Gertrude ?</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mrs. Joyce M. Kidwell-Bowie, Maryland</u> | | Address <u></u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> DUE TO <u>171X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Cervix</u> DUE TO <u></u> (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH <u>10 mo</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Aug 14</u> , 19 <u>56</u> , to <u>Sept 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 4</u> , 19 <u>56</u> , and that death occurred at <u>11:54</u> A.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Morton C. Creditor</u> M.D. | | ADDRESS (Street, city or town, state) <u>Washington, D.C.</u> | |
| PHYSICIAN'S NAME (Type) <u>MORTON C. CREDITOR</u> | | DATE SIGNED <u>Washington, D.C.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>9/8/1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u> | 22d. LOCATION (City, town, or county) (State) <u>Frederick Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robt. A. Pumphrey-7557 Wis. Ave. Bethesda, Md</u> | | 24a. REC'D BY REGISTRAR DATE <u>9-8-56</u> | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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03

Mrs. Joyce M. Kidwell-Howe, Maryland

BUREAU V. S.

SEP 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9509

CERTIFICATE OF DEATH

09495

Reg. Dist. No. 217

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|---|--------------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ashton | | c. LENGTH OF STAY IN 1b 89 Years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) Mariana First Stabler Middle Miller Last | | 4. DATE OF DEATH Sept Month 8 Day 19 Year 56 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 16 1866 |
| 9. AGE (In years last birthday) 89 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Charles Stabler | | 14. MOTHER'S MAIDEN NAME Sarah Kirk | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ##### (If yes, give year or date of service) ##### | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Robert H. Miller Jr. Address Ashton, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting aortic aneurysm DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs 20 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan , 19 56 , to Sept , 19 56 , that I last saw the deceased alive on Sept 7 , 19 56 , and that death occurred at 7:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9/8/56 | | | |
| ACTUAL SIGNATURE A. D. Bonifant | | M.D. Sandy Spring, Md. | |
| PHYSICIAN'S NAME (Type) A. D. BONIFANT | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 22b. DATE THEREOF Sept. 8, 56 | 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln | 22d. LOCATION (City, town, or county) (State) Prince George Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Moyaw Barber ADDRESS Laytonsville, Md. | | 24a. REC'D BY REGISTRAR 9-10-56 24b. REGISTRAR'S SIGNATURE Gerardo B. Lawler | |

CERTIFICATE OF DEATH

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BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9510

CERTIFICATE OF DEATH

09496

Reg. Dist. No. 217

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|---|----------------------------------|---|------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | | | c. LENGTH OF STAY IN 1b <u>18 hours</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u> | | | | d. STREET ADDRESS <u>Rt. # 2</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Lydia</u> Middle <u>Estelle</u> Last <u>Murphy</u> | | | | 4. DATE OF DEATH Month <u>September</u> Day <u>5</u> Year <u>19 56</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/29/95</u> | | 9. AGE (In years last birthday) <u>61</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Jacob Leahman</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Florence Duvall</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>181X</u> | | 17. INFORMANT <u>Hospital Record (Daughter)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of bladder</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>Sept</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 4</u> , 19 <u>56</u> , and that death occurred at <u>4:15 A</u> .M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>A. D. Bonifant</u> | | | | ADDRESS (Street, city or town, state) <u>Sandy Spring, Md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>A. D. Bonifant, M. D.</u> | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>SEPT 7 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Union Burialville</u> | | 22d. LOCATION (City, town, or county) (State) <u>Montgomery Co Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W Barber</u> | | | | ADDRESS <u>Jaytownsville, Ind</u> | | 24a. REC'D BY REGISTRAR <u>9-6-56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Lester B Lawler</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

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| NAME OF DECEASED | | DATE OF DEATH | |
| PLACE OF DEATH | | AGE | |
| OCCUPATION | | SEX | |
| EDUCATION | | RACE | |
| MARRIAGE | | RELIGION | |
| CAUSE OF DEATH | | MANNER OF DEATH | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF REGISTRAR | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | |

RECEIVED
 SEP 10 1956
 BUREAU V. 1

VS A15 (4)
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VS A15 (4)
15M 9/55

89497
Reg. Dist. No. 223

9427

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| 1. PLACE OF DEATH a. COUNTY <u>Montgomery.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>A.A.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | d. STREET ADDRESS <u>Old Ft Mead Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Infant.</u> First Middle Last | | 4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>1956</u> | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9-12-56</u> | |
| 9. AGE (In years last birthday) yrs. | | IF UNDER 1 YEAR Months <u>2</u> Days <u>14</u> Hours <u>—</u> Min. <u>—</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>—</u> | |
| 13. FATHER'S NAME <u>Bernard Eugene Nichols</u> | | 14. MOTHER'S MAIDEN NAME <u>Eva Maria Woody.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Hospital Records.</u> | | Address <u>—</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atelectasis</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9/13</u> <u>1956</u> to <u>9/13</u> <u>1956</u> , that I last saw the deceased alive on <u>9/13/1956</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <u>8224- ga ave silver spring Md</u> DATE SIGNED <u>U.H. Diamond</u> | |
| ACTUAL SIGNATURE <u>U.H. Diamond</u> M.D. | | PHYSICIAN'S NAME (Type) <u>U.H. DIAMOND M.D.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9/15/56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Ingalls Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Laurel Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. W. H. Connelley</u> ADDRESS <u>Laurel, Md.</u> | | 24a. REC'D BY REGISTRAR <u>9/19/56</u> DATE | |
| 24b. REGISTRAR'S SIGNATURE <u>J. H. H. H. H.</u> | | | |

2175213XV3

MARKYARD STATE DEPARTMENT OF HEALTH—BIRMINGHAM 18

BUREAU V. S.

SEP 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09498

Item 9 Film G204, 9-19-56 et

9511

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | | | | | |
|---|----------------------------------|--|------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 4 mos. 11 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | | | d. STREET ADDRESS 1324 Potomac Ave., S.E. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Lawrence Middle Joseph Last NOLAN | | 4. DATE OF DEATH Month September Day 11 Year 19 56 | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-20-85 | 9. AGE (In years last birthday) 71 yrs. | IF UNDER 1 YEAR Months 19 Days 7 Hours 1 Min. 1 | IF UNDER 24 HRS. Hours 1 Min. 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired) | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Michael Thomas Nolan | | | | 14. MOTHER'S MAIDEN NAME Abigail Driscoll | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW-1 <input checked="" type="checkbox"/> WW-2 <input checked="" type="checkbox"/> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Official Navy Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Rectum, Metastatic to left hip 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH 15 years | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from 30 April , 19 56 , to 11 Sept. , 19 56 , that I last saw the deceased alive on 11 Sept , 19 56 , and that death occurred at 10:42A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE R.G. Williams M.D. U.S. Naval Hospital, Bethesda, Maryland PHYSICIAN'S NAME (Type) R.G. WILLIAMS, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md. 9-11-56 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 14 Sept. 56 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) _____ (State) _____ Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J.T. RYAN J.T. RYAN Funeral Home 317 Penn. Ave., S.E. | | | | 24a. REC'D BY REGISTRAR DATE 9-11-56 | | 24b. REGISTRAR'S SIGNATURE May E. Parselley | |

CERTIFICATE OF DEATH

STATE OF NEW YORK

BUREAU V. S.

SEP 13 1956

RECEIVED

9512 CERTIFICATE OF DEATH

09499

Reg. Dist. No. 212

| | | | |
|---|---------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Boyd's</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Boyd's</u> STREET ADDRESS (If rural give location) | |
| 3. NAME OF DECEASED (Type or Print) (First) <u>Norie</u> (Middle) <u>E</u> (Last) <u>Norris</u> | | 4. DATE OF DEATH (Month) <u>Sept</u> (Day) <u>24</u> (Year) <u>1956</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>March 12-1870</u> |
| 9. AGE last birthday <u>86</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME <u>Jacob Dutron</u> | | 14. MOTHER'S MAIDEN NAME <u>Janie Williams</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT & ADDRESS <u>Mrs Norine Dahn - Boyd's Md</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | |
| 331X IMMEDIATE CAUSE (A) <u>Hypostatic Pneumonia</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Vascular Accident (Hemiplegia)</u> | | <u>8 day</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cerebral Arteriosclerosis with Hypertension</u> | | <u>4 years</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Obesity</u> | | <u>10 years</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>June, 1955</u> , to <u>24 Sept, 1956</u> , that I last saw the deceased alive on <u>23 Sept, 1956</u> , and that death occurred at <u>2:45</u> A.M. from the causes and on the date stated above. | | | |
| SIGNATURE <u>John M Smith</u> | | ADDRESS (Street, city, town, state) <u>BARNESVILLE, Md.</u> DATE SIGNED <u>24 Sept 56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>9/26/56</u> NAME OF CEMETERY OR CREMATORY <u>Monocacy</u> LOCATION (City, town, or county) (State) <u>Beallsville Md</u> | |
| 24. REC'D BY REGISTRAR <u>Charles W. Elgin</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u> ADDRESS <u>Barnesville Md</u> | |

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

RECEIVED
SEP 28 1956
BUREAU V. S.

THIS CERTIFICATE OF DEATH is to be filled out by the attending physician or other qualified person, and is to be filed with the local health officer. It is to be filled out for every person who dies in this State, whether the death is natural, accidental, or suicidal. It is to be filled out for every person who dies in this State, whether the death is natural, accidental, or suicidal. It is to be filled out for every person who dies in this State, whether the death is natural, accidental, or suicidal.

9513

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No

214

| | | | | | | | |
|--|----------------------------------|---|------------------------------------|---|--------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring | | | | c. LENGTH OF STAY IN 1b 56 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 00 8010 Eastern Drive, Apt. T-2 | | | | d. STREET ADDRESS 8010 Eastern Drive, Apt T-2 | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Frances Marion O'Brien | | | | 4. DATE OF DEATH Month Day Year 9/22/56 19 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/30/17 | 9. AGE (In years last birthday) 39 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) store clerk, Secretary Jacobs Paper Firm | | | | 10b. KIND OF BUSINESS OR INDUSTRY Vermont | | 11. BIRTHPLACE (State or foreign country) USA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Harry D. Richards | | | | 14. MOTHER'S MAIDEN NAME Lena Miner | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no | | | | 16. SOCIAL SECURITY NO. 008-05-7357 | | 17. INFORMANT Mr. Arthur J. O'Brien, 8010 Eastern Ave. Silver Spring, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 543X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aspiration of stomach contents (c) Acute gastritis | | | | INTERVAL BETWEEN ONSET AND DEATH 15 min 48 hrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Interment Burial 9/24/56 | | | | 22b. DATE THEREOF 9/24/56 | | 22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | |
| 22d. LOCATION (City, town, or county) WASHINGTON, D.C. JERSEY | | | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey | | | | 24a. REC'D BY REGISTRAR 9/26/56 | | 24b. REGISTRAR'S SIGNATURE Frances Potter | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

RECEIVED

SEP 28 1956

BUREAU V. 8

*Capitulation of about 1000
Cute pictures*

*12-11
11
48-11*

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09501

9514

CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | | | | | |
|--|---------------------------|--|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <u>11909- ANDREW ST</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>DENNIS</u> Middle <u>JOSEPH</u> Last <u>O'CONNELL</u> | | | | 4. DATE OF DEATH Month <u>SEPT.</u> Day <u>8th</u> Year <u>1956</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN 1ST 1876</u> | 9. AGE (In years last birthday) <u>80</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV.</u> | | 11. BIRTHPLACE (State or foreign country) <u>IRELAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>DANIEL J. O'CONNELL</u> | | | | 14. MOTHER'S MAIDEN NAME <u>BRIDGET FEALY</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>MARY GENTILE</u> Address <u>11909- ANDREW ST.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intractable Heart Failure</u> <u>420.0</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal Bronchopneumonia</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>September 9/8</u> , 19 <u>54</u> , to <u>9/8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/8</u> , 19 <u>56</u> , and that death occurred at <u>8:58 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>J. Blaine Fitzgerald</u> | | M.D. <u>8218 Wisconsin Ave. Bethesda, Md.</u> | | DATE SIGNED <u>9/8/56</u> | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <u>9-11-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Anthony Haulon</u> | | ADDRESS <u>3831 Ya Ave NW</u> | | 24a. REC'D BY REGISTRAR <u>9/13/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Frances [Signature]</u> | |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

File No.

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|---------------|--|----------------|--|------------------------|--|------------------------|--|---------------------|--|---------------------|--|-----------------|--|---------------|--|----------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Manner of Death | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| JAMES H. SMITH | | Male | | 45 | | 1911 | | Maryland | | Natural | | Heart Disease | | 1956 | | 10:00 AM | | Home | | J. H. Smith | | J. H. Smith | |
| Occupation | | Education | | Marital Status | | Previous Illnesses | | Last Illness | | Duration of Illness | | Attending Physician | | Medical History | | Autopsy | | Burial | | Funeral Home | | Remarks | |
| Teacher | | High School | | Married | | Hypertension | | Chest Pain | | 2 Weeks | | Dr. J. H. Smith | | None | | No | | Buried | | Smith & Sons | | None | |
| Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | | Remarks | | Remarks | | Remarks | | Remarks | | Remarks | | Remarks | | Remarks | |
| 1956 | | 10:00 AM | | Home | | J. H. Smith | | J. H. Smith | | None | | None | | None | | None | | None | | None | | None | |

BUREAU V. 3

SEP 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9516 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09503

Reg. Dist. No. 216

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5063 Bradley Boulevard | | | | d. STREET ADDRESS 5063 Bradley Boulevard | | | |
| 3. NAME OF DECEASED (Type or print) First Philip Middle PADGETT Last PADGETT | | | | 4. DATE OF DEATH Month Sept. Day 5 Year 19 56 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 11, 1899 | | 9. AGE (In years last birthday) 57 yrs. | IF UNDER 1 YEAR Months 4 Days 24 | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard | | 10b. KIND OF BUSINESS OR INDUSTRY Gen. Services Adm | | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Wilbur L. Padgett | | | | 14. MOTHER'S MAIDEN NAME Mary L. DeMent | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W. W. II | | 16. SOCIAL SECURITY NO. 435-38-1229 | | 17. INFORMANT John D. Padgett-White Plains, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage & laceration DUE TO Conditions, if any, which gave rise to immediate cause (b) Bullet wound through skull (c) sudden PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Self-inflicted bullet wound through skull | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self-inflicted bullet wound through skull | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour ? o. m. 9/3/56 p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) (County) (State) Bethesda Montg. Maryland | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) Frank J. Broschart, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | DATE SIGNED Sept. 5, 1956 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 9/6/1956 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 22d. LOCATION (City, town, or county) (State) Prince Georges Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robt. A. Pumphrey-7557 Wisconsin Ave. Be th. Md. | | | | 24a. REC'D BY REGISTRAR 9-8-56 | | 24b. REGISTRAR'S SIGNATURE <i>Hannie M. Thompson</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9515

CERTIFICATE OF DEATH

Reg. Dist. No.

09502
214

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE RHODE ISLAND b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | | | c. LENGTH OF STAY IN 1b 3 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15,400 Norwood Pike | | | | d. STREET ADDRESS 1 | | | |
| 3. NAME OF DECEASED (Type or print) First FRANK Middle ALLEN Last PAGE | | | | 4. DATE OF DEATH Month SEPT. Day 15 Year 1956 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH MAY 4, 1878 | |
| 9. AGE (In years lost birthday) 78 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTOM BROKER | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) JOHNSTON, RHODE ISLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME SIMON PAGE | | | | 14. MOTHER'S MAIDEN NAME CORLISTA BATHELDER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Chester H. Page, 15,400 Norwood Pike Silver Spring, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate & metastasis 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH 6 yrs | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan , 1953, to Sept , 1956, that I last saw the deceased alive on Sept 15 , 1956, and that death occurred at 5 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED AD Bryant M.D. Samuel Sping 9/16/56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) A.D. BRYANT | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) TRNSA. & BURIAL | | 22b. DATE THEREOF 9/16/56 | | 22c. NAME OF CEMETERY OR CREMATORY OAKGROVE CEMETERY | | 22d. LOCATION (City, town, or county) (State) FALL RIVER, MASS. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey | | | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR DATE 9-17-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Frances | | | |

MEDICAL CERTIFICATION

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RECEIVED
SEP 19 1956
BUREAU V. S.

SEP 19 1956

9428

CERTIFICATE OF DEATH

Reg. Dist. No.

223

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN TB <u>3 hours</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Marquerite Cecilia Peacock</u> | | 4. DATE OF DEATH Month Day Year <u>Sept 19 1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Cauc</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 2 1895</u> |
| 9. AGE (In years last birthday) <u>61</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Cleveland - William</u> | | 14. MOTHER'S MAIDEN NAME <u>Pauline Conveyer</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Francis Peacock - same address</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of wall of left ventricle</u> 420.1 DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis & hypertension</u> DUE TO (c) <u>Arteriosclerosis & hypertension</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>4 hr.</u> <u>years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>9-19-56</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9-19-56</u> , 1956, to <u>9-19-56</u> , 1956, that I last saw the deceased alive on <u>9-19-56</u> , 1956, and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | ADDRESS (Street, city or town, state) <u>927 Pershing Dr.</u> | |
| PHYSICIAN'S NAME (Type) <u>A. W. DAVIS</u> | | DATE SIGNED <u>9-19-56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | 22b. DATE THEREOF <u>9/22/56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>George Wash. Mem. Pk. Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> | | ADDRESS <u>2901-14 1st St. N.W. Wash. D.C.</u> | |
| 24a. REC'D BY REGISTRAR <u>[Signature]</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAVY AND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 5

SEP 25 1956

RECEIVED

9517

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|---|-------------------------------|--|--------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>10 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | Route <u>2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | | | d. STREET ADDRESS <u>Box 69</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNE DORA Pendleton</u> | | | | 4. DATE OF DEATH Month Day Year <u>September 17 1956</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/6/10</u> | | 9. AGE (in years last birthday) <u>46</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Audress - domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>JENNIE Pendleton</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Ellen Hill - Rt. 2 Box 69 Rockville Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism, Bil.</u> 466X DUE TO <u>Thrombosis, iliac Veins - (?)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) Bil. Tubo-Cranial Abscess (2) Tuberculous</u> INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9/11</u> , 19 <u>56</u> , to <u>9/17</u> , 19 <u>56</u> that I last saw the deceased alive on <u>9/17</u> , 19 <u>56</u> , and that death occurred at <u>7:07 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <u>Georgina Wallace</u> M.D. | | | | PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9/22/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Moses #10</u> | | 22d. LOCATION (City, town, or county) (State) <u>Cabin John, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert L. Swenden - Rockville, Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>9/22/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9433

CERTIFICATE OF DEATH

09506

Reg. Dist. No.

| | | | | | | | |
|--|---|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Radford | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Waverley Sanitarium | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last AUGUSTUS HAYES PENFIELD | | | | 4. DATE OF DEATH Month Day Year Sept. 25, 19 56 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 31, 1874 | 9. AGE (In years last birthday) yrs. 81 | IF UNDER 1 YEAR Months Days 10 21 | IF UNDER 24 HRS. Hours Min. 10 21 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Broker | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Springfield, Ohio | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Fletcher S. Penfield | | | | 14. MOTHER'S MAIDEN NAME Sara Florence Bassett | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mrs Bruce Davis- 8802 Lowell Place, Beth., Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Arterio sclerosis Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 332x DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs 12 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that I attended the deceased from 7-31 , 19 56 , to 9-25 , 19 56 , that I last saw the deceased alive on 9-25 , 19 56 , and that death occurred at 8:15 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Joseph H. Watson M.D. 4600 Waverley Ave. Garrett Park, Md. | | | | DATE SIGNED 9-25-56 | | | |
| PHYSICIAN'S NAME (Type) Joseph H. Watson- 4600 Waverley Ave. Garrett Park, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Tr. | 22b. DATE THEREOF 9/26/56 | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) East Orange, N. J. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR DATE 9/27/56 | | 24b. REGISTRAR'S SIGNATURE Russell Maglorp per E.C. | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAXFORD STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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1. *Book 1*

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DAY 1

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Oct. 31, 1934

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Ref. 13061

Springfield, Ohio

Richard J. Penfield

2107

BUREAU V. S.

SEP 28 1956

RECEIVED

Robert A. Thompson-Hernandez, M.D.

8/30/02

1997-1998

Joseph H. Watson - 4500 W.

9518

CERTIFICATE OF DEATH

09507
Reg. Dist. No. 218

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Fred</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dathersburg</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u> 1035-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home (Hospital)</u> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>VIRGINIA</u> Last <u>PEYTON</u> | | 4. DATE OF DEATH <u>September 7</u> 19 <u>56</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 6 - 1867</u> |
| 9. AGE (In years lost birthday) <u>88</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Culpepper, Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Alexander Oden</u> | | 14. MOTHER'S MAIDEN NAME <u>Annie Mc Donald</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT Address <u>Mrs. Lacey L. Forney, Brunswick, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary congestion</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral hemorrhage RT. side</u> DUE TO (c) <u>hypertension + arteriosclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>16 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>MARCH</u> 19 <u>56</u> , to <u>September</u> 19 <u>56</u> , that I last saw the deceased alive on <u>September 5, 1956</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>4208 Anthony St. Kensington Md. 9-7-56</u> | | | |
| ACTUAL SIGNATURE <u>Sarah E. Glover</u> | | M.D. <u>4208 Anthony St. Kensington Md. 9-7-56</u> | |
| PHYSICIAN'S NAME (Type) <u>Sarah E. Glover</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>9/9/1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Park Heights</u> | 22d. LOCATION (City, town, or county) (State) <u>Brunswick, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Frest. Br...</u> | | ADDRESS <u>Brunswick</u> | |
| 24a. REC'D BY REGISTRAR <u>SEP 11 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>C. H. Frest. Br...</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9519 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09508

Reg. Dist. No. 216

| | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7605 Old Chester Road</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>7605 Old Chester Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Ferdinand</u> Last <u>POCH</u> | | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>5</u> Year <u>19 56</u> | | | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Jne 10, 1898</u> | | 9. AGE (In years last birthday) <u>58</u> yrs. | | IF UNDER 1 YEAR Months <u>2</u> Days <u>25</u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Owner</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | | | |
| 13. FATHER'S NAME <u>F. C. Poch</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine ?</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <u>yes</u> <u>WW 1</u> | | | | 16. SOCIAL SECURITY NO. <u>WW 1</u> | | | | 17. INFORMANT <u>Robert A. Poch-Item # 2</u> | | | | Address <u> </u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal hemorrhage</u> DUE TO (b) <u>Shotgun wound in upper left abdomen</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Self-inflicted gunshot wound</u> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in attic of his home</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Self-inflicted gunshot wound</u> | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u>9/5/56</u> 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | | | 20f. (City or town) <u>Bethesda</u> | | (County) <u>Montg.</u> | | (State) <u>Maryland</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. | | | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>Sept. 5, 1956</u> | |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart, M.D.</u> | | | | | | | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>9/8/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u> | | | | 22d. LOCATION (City, town, or county) <u>Prince George, Md.</u> | | | | (State) <u> </u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> | | | | | | | | | | | | 24a. REC'D BY REGISTRAR <u>8-8-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u> | |

MEDICAL CERTIFICATION

2

80

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. No burial, cremation, or removal.

SEP 10 1956

BUREAU V. &

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O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 16 Film G201 10-3-56 et

9520

CERTIFICATE OF DEATH

09500

Reg. Dist. No.

214

| | | | |
|--|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Fredrick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u> | |
| c. LENGTH OF STAY IN 1b <u>4 WKS</u> | | d. STREET ADDRESS <u>Route 2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedarcroft San. & Hosp</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Morton</u> Middle <u>McNutt</u> Last <u>Prentiss</u> | | 4. DATE OF DEATH Month <u>Sept</u> Day <u>28</u> Year <u>1956</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 2, 1887</u> |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Henning Webb</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Morton McNutt</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>217-14-1101</u> | |
| 17. INFORMANT <u>son - Morton Prentiss, Jr.</u> | | Address <u>Thurmont, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> 491X DUE TO (b) <u>about 1 wk.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral and general arteriosclerosis & psychosis</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | |
| 21. I certify that I attended the deceased from <u>Aug 31, 1956</u> to <u>Sept 28, 1956</u> that I last saw the deceased alive on <u>Sept 27, 1956</u> , and that death occurred at <u>12:09 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Alvin J. Kistler</u> | | ADDRESS (Street, city or town, state) <u>Cedarcroft San. & Hosp. Silver Spring</u> | |
| PHYSICIAN'S NAME (Type) <u>ALVIN J. KISTLER</u> | | DATE SIGNED <u>SEP 28 1956</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Sept 30-1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>New Provident Presby. Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Rockbridge County Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond G. Treagan</u> ADDRESS <u>Thurmont, Md</u> | | | |
| 24a. REC'D BY REGISTRAR <u> </u> DATE <u>1 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>James Potters</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

OCT 2 1956

RECEIVED
OCT 2 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9521 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09510

Reg. Dist. No. 216

| | | | | | | | | |
|--|--|---|--|--|--|--|---|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4218 Colchister Rd. | | | | d. STREET ADDRESS 4218 Colchester Rd. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Guy Middle Max Last Purdue Harold | | | | 4. DATE OF DEATH 8/9/56 Day 9/9/56 Year 19 | | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7/17/56 | | |
| 9. AGE (In years last birthday) 1 yrs. | | 10. IF UNDER 1 YEAR Months 1 Days 23 | | 11. IF UNDER 24 HRS. Hours 23 Min. | | 12. CITY OF WHAT COUNTRY? USA | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | | | 10b. KIND OF BUSINESS OR INDUSTRY D.C. | | | | |
| 13. FATHER'S NAME Troy D. Purdue | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT (father) #2 Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema, glottis 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia, confluent both lungs DUE TO (c) ? INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| 20f. (City or town) (County) (State) | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED 9/10/56 |
| EXAMINER'S NAME (Type) Frank J. Broschart | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/12/56 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington National | | 22d. LOCATION (City, town, or county) Arlington, Virginia | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland | | | | ADDRESS | | 24a. REC'D BY REGISTRAR 9-10-56 | | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | |

9VVVVVVVVVV

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9522

CERTIFICATE OF DEATH

Reg. Dist. No. 095117

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sharon Chronic Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Virgie W Purvis</u> | | 4. DATE OF DEATH <u>Sept 4 1956</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 5, 1884</u> |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>29</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Bethesda Monto-Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William Fyles</u> | | 14. MOTHER'S MAIDEN NAME <u>Lula Paxton</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u> | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT <u>Mrs Samuel Purvis, Sharon-Hosp-Md</u> | | Address <u>Olney</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Sen. art. Sclerotic Cardio Vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>old c.v.a.</u> (b) <u></u> (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>10 yrs</u> <u>5</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> | 20f. (City or town) (County) (State) <u></u> |
| 21. I certify that I attended the deceased from <u>Jan - 24</u> , 19 <u>56</u> , to <u>Sept 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 4</u> , 19 <u>56</u> , and that death occurred at <u>4:00</u> P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John B. Bogler</u> M.D. | | ADDRESS (Street, city or town, state) <u>Olney Md</u> | |
| PHYSICIAN'S NAME (Type) <u>Dr. John B. Bogler</u> | | DATE SIGNED <u>4 Sept 56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>9-7-56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Church Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Montgomery Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | ADDRESS <u>Bethesda, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>9-5-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u> | |

Name: *William H. Jones*
 Sex: *Male*
 Date of Birth: *Dec. 3, 1884*
 Place of Birth: *Bethesda, Mont. Md.*
 Usual Residence: *Bethesda, Mont. Md.*
 Present Residence: *Bethesda, Mont. Md.*
 Cause of Death: *Heart failure*
 Date of Death: *Sept 4, 1935*
 Place of Death: *Bethesda, Mont. Md.*
 Physician: *Dr. John B. Bickel*
 Burial Place: *Greenwood Cemetery*
 Signature: *John B. Bickel*
 Registrar: *John B. Bickel*
 Date: *Sept 4, 1935*
 Office: *Bethesda, Mont. Md.*
 County: *Montgomery*
 State: *Mont. Md.*

RECEIVED
 SEP 10 1935
 BUREAU V. S.
 HEALTH DEPARTMENT
 BALTIMORE, MD

9523

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON DC b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA | | | | c. LENGTH OF STAY IN 1b 21 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RESTOR SANATARIUM | | | | d. STREET ADDRESS 4345 NEBRASKA AVE NW | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MARY MAGDALIN RABBIT | | | | 4. DATE OF DEATH Month Day Year Sept 7 1956 | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 25 July 1872 | |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Alexandria VA, | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME PETER KLINE | | | | 14. MOTHER'S MAIDEN NAME DRURY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL Thrombosis 332 X DUE TO (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE, DECOMPENSATED 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. NONE 20d. INJURY OCCURRED White Not white at work at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from July 29, 1956 , to Sept 7, 1956 that I last saw the deceased alive on Sept 7, 1956 , and that death occurred at 11:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SEPT 7/56 DATE SIGNED ACTUAL SIGNATURE Lewis H. Biben M.D. 703 FARRAGUT MED BLDG 900-17TH ST NW, WASHINGTON DC PHYSICIAN'S NAME (Type) LEWIS H. BIBEN | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 9/10/56 | | 22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK | | 22d. LOCATION (City, town, or county) (State) WASH. DC. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph F. Birch's Sons 3034 M ST NW, DC. | | | | 24a. REC'D BY REGISTRAR DATE 9-10-56 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9524

CERTIFICATE OF DEATH

09513

Reg. Dist. No. 215

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Mar Park | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland | | d. STREET ADDRESS 5306 Augusta Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle Henry Last REDDING | | 4. DATE OF DEATH Month September Day 18 Year 19 56 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-14-06 |
| 9. AGE (In years last birthday) 50 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy | |
| 11. BIRTHPLACE (State or foreign country) Canada | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME John H. Redding | | 14. MOTHER'S MAIDEN NAME Jane Wasson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-II | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Mrs. Grace T. Redding (Wife) | | Address (Same As #2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Generalized Carcinoma DUE TO (c) Adenocarcinoma, Left kidney PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs 14 mo 20 mo | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1 May , 19 56 , to 18 Sept. , 19 56 , that I last saw the deceased alive on 18 Sept. , 19 56 , and that death occurred at 02:50 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Arthur J. Johnson M.D. | | ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 9-18-56 | |
| PHYSICIAN'S NAME (Type) Arthur J. Johnson, LT, MC, USN | | U.S. Naval Hospital, Bethesda, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-21-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey R.A. Pumphrey Funeral Home, 7557 Wisconsin Ave. | | 24a. REC'D BY REGISTRAR DATE 9-18-56 | |
| 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly | | | |

RECEIVED

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|-------------------------|--|-----------------------|--|------------------------|--|----------------------|--|----------------------|--|---------------------------|--|------------------------|--|------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | |
| | | | | | | | | | | | | | | | |
| 9. OCCUPATION | | 10. MARITAL STATUS | | 11. EDUCATION | | 12. RELIGION | | 13. DATE OF MARRIAGE | | 14. DATE OF DIVORCE | | 15. DATE OF REMARRIAGE | | 16. DATE OF DEATH | |
| | | | | | | | | | | | | | | | |
| 17. CAUSE OF DEATH | | 18. MANNER OF DEATH | | 19. MEDICAL HISTORY | | 20. PRESENT ILLNESS | | 21. TREATMENT | | 22. PHYSICIAN'S SIGNATURE | | 23. DATE OF SIGNATURE | | 24. PLACE OF SIGNATURE | |
| | | | | | | | | | | | | | | | |
| 25. CORONER'S SIGNATURE | | 26. DATE OF SIGNATURE | | 27. PLACE OF SIGNATURE | | 28. CORONER'S OFFICE | | 29. COUNTY | | 30. STATE | | 31. ZIP CODE | | 32. TELEPHONE | |
| | | | | | | | | | | | | | | | |

BUREAU V. S.

SEP 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9526

CERTIFICATE OF DEATH

Reg. Dist. No. 09515

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Florida b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 8 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pensacola | | 48 X - 3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | d. STREET ADDRESS Route #1 Box 218G | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Michael Middle Jerome Last RICKER | | 4. DATE OF DEATH Month September Day 13 Year 1956 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 20 May 1956 |
| 9. AGE (In years last birthday) 3 yrs | | IF UNDER 1 YEAR Months 15 Days 15 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Florida | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME John Junior RICKER | | 14. MOTHER'S MAIDEN NAME Ruth BROWN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT (Father) John J. RICKER | | Address (Same As #2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis + Congestive Heart Failure 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Co Tricuspid Atresia (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 48 hours 5 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5 September, 1956 , to 13 September, 1956 , that I last saw the deceased alive on 13 September, 1956 , and that death occurred at 9:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John H. Mazur M.D. U.S. Naval Hospital, Bethesda, Md. 9-14-56 | | | |
| ACTUAL SIGNATURE John H. Mazur, LT.MC, USN | | PHYSICIAN'S NAME (Type) U.S. Naval Hospital, Bethesda, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-17-56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Taylor Cemetery | | 22d. LOCATION (City, town, or county) (State) Taylor, Florida | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey | | ADDRESS Bethesda, Md. | |
| 24a. REC'D BY REGISTRAR 9-14-56 | | 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09516

9527

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6915 Strathmore St. | | | | d. STREET ADDRESS 6915 Strathmore St. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) ELIZA First R. Middle RIDGWAY Last | | | | 4. DATE OF DEATH September 5, Month 10 Day 9 Year 19 56 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 27, 1873 | |
| 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR Months 10 Days 9 | | IF UNDER 24 HRS. Hours 9 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None -Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) New Jersey | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Caleb C. Ridgway | | | | 14. MOTHER'S MAIDEN NAME Annie Rogers | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Miss Helen L. Taylor-Item # 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized arteriosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8-3- , 19 56 , to 9-5- , 19 56 , that I last saw the deceased alive on 9-4- , 19 56 , and that death occurred at 6:25 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda, Md. DATE SIGNED Sept. 5, 1956 | | | | | | | |
| ACTUAL SIGNATURE George A. Gray, Jr. | | | | PHYSICIAN'S NAME (Type) George A. Gray, Jr. 104 Chevy Chase Dr., Chevy Chase, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit | | 22b. DATE THEREOF 9/6/56 | | 22c. NAME OF CEMETERY OR CREMATORY St. Marys | | 22d. LOCATION (City, town, or county) (State) Burlington, New Jersey | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey | | | | ADDRESS Bethesda, Md. | | 24a. REC'D BY REGISTRAR DATE 9-8-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 1966
BUREAU V. 3

9528

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Rockville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Rockville</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD Rockville</u> | | | | d. STREET ADDRESS <u>R.F.D. Rockville</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>H.</u> Middle <u>ROBERTS</u> Last | | | | 4. DATE OF DEATH <u>September 25,</u> 19 <u>56</u> Month <u>September</u> Day <u>25</u> Year <u>1956</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 24, 1870</u> | |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | IF UNDER 1 YEAR <u>2</u> Months <u>1</u> Days | | IF UNDER 24 HRS. <u>1</u> Hours <u>1</u> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME <u>John Roberts</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Florence Roberts</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mary Burrows- Item # 2</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>30 yrs</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May</u> 19 <u>56</u> , to <u>25 Sept</u> 19 <u>56</u> , that I last saw the deceased alive on <u>25 Sept</u> 19 <u>56</u> , and that death occurred at <u>10:57 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>W.S. Murphy</u> | | | | ADDRESS (Street, city or town, state) <u>615 W. Montgomery Ave. Rockville, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Dr. W.S. Murphy</u> | | | | DATE SIGNED <u>25 Sept 56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9-28-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Presby Ch.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Montgomery Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | | | ADDRESS <u>Bethesda, Md</u> | | 24a. REC'D BY REGISTRAR <u>9/27/56</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Lawrence Kragtorp</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

9529

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Moreland Hills</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Moreland Hills</u> | |
| c. LENGTH OF STAY IN 1b <u>6 Yrs</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5202 Abingdon Rd.</u> | | d. STREET ADDRESS <u>5202 Abingdon Road</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>J. ROSSER</u> Last <u>BOESSER</u> | | 4. DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1956</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 16, 1869</u> |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Frostburg, Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John Jones</u> | | 14. MOTHER'S MAIDEN NAME <u>Harriett Bowen</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>Mrs Donald M. Merritt, 5202 Abingdon Rd</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331x</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastatic Carcinoma</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> |
| 21. I certify that I attended the deceased from <u>January</u> , 19 <u>56</u> , to <u>September 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>September 15</u> , 19 <u>56</u> , and that death occurred at <u>11:15 A.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Frederick W. Coe</u> | | ADDRESS (Street, city or town, state) <u>1835 Eye St., N.W., Washington D.C.</u> DATE SIGNED <u>9/16/56</u> | |
| PHYSICIAN'S NAME (Type) <u>Frederick W. Coe, 1835 Eye St. N.W., Washington, D.C.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>9/20/56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Inglewood Park Cem</u> | 22d. LOCATION (City, town, or county) (State) <u>Los Angeles, California</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph L. Jones</u> ADDRESS <u>1756 Pa. Ave. NW, DC</u> | | 24a. REC'D BY REGISTRAR <u> </u> DATE <u>9/22/56</u> | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|--|--|
| DECEASED NAME J. ROBERT BOODER | | SEX M | | AGE 35 | |
| DATE OF DEATH 9-15-1956 | | PLACE OF DEATH 3802 Abingdon Rd. | | CITY BALTIMORE | |
| COUNTY BALTIMORE | | STATE MARYLAND | | ZIP CODE 21206 | |
| DECEASED'S RESIDENCE 3802 Abingdon Rd. | | PLACE OF BIRTH [illegible] | | DATE OF BIRTH [illegible] | |
| DECEASED'S OCCUPATION [illegible] | | CAUSE OF DEATH [illegible] | | MANNER OF DEATH [illegible] | |
| DECEASED'S MARITAL STATUS [illegible] | | DECEASED'S RACE [illegible] | | DECEASED'S COLOR [illegible] | |
| DECEASED'S RELIGION [illegible] | | DECEASED'S EDUCATION [illegible] | | DECEASED'S SERVICE [illegible] | |
| DECEASED'S SOCIAL SECURITY NUMBER [illegible] | | DECEASED'S VETERAN STATUS [illegible] | | DECEASED'S MILITARY SERVICE [illegible] | |
| DECEASED'S EMPLOYER [illegible] | | DECEASED'S EMPLOYMENT STATUS [illegible] | | DECEASED'S EMPLOYMENT DATE [illegible] | |
| DECEASED'S EMPLOYMENT ADDRESS [illegible] | | DECEASED'S EMPLOYMENT PHONE [illegible] | | DECEASED'S EMPLOYMENT CITY [illegible] | |
| DECEASED'S EMPLOYMENT STATE [illegible] | | DECEASED'S EMPLOYMENT ZIP CODE [illegible] | | DECEASED'S EMPLOYMENT COUNTRY [illegible] | |

BUREAU A. 3

SEP 25 1956

RECEIVED

PROBATIONER W. Lee, 1956

DECEASED'S SOCIAL SECURITY NUMBER

DECEASED'S VETERAN STATUS

DECEASED'S MILITARY SERVICE

DECEASED'S EMPLOYER

DECEASED'S EMPLOYMENT STATUS

DECEASED'S EMPLOYMENT DATE

DECEASED'S EMPLOYMENT ADDRESS

DECEASED'S EMPLOYMENT PHONE

DECEASED'S EMPLOYMENT CITY

DECEASED'S EMPLOYMENT STATE

DECEASED'S EMPLOYMENT ZIP CODE

DECEASED'S EMPLOYMENT COUNTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9530

CERTIFICATE OF DEATH

Reg. Dist. No. 215

09519

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 4 mos. 5 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland | | | | d. STREET ADDRESS 1212 37th Street | | | |
| 3. NAME OF DECEASED (Type or print) First Margaret Middle Elizabeth Last ROUSH | | | | 4. DATE OF DEATH Month September Day 2 Year 1956 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9 July 1911 | |
| 9. AGE (In years last birthday) 45 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Waves) | | 11. BIRTHPLACE (State or foreign country) West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | 13. FATHER'S NAME Arthur Roy ROUSH | | | |
| 14. MOTHER'S MAIDEN NAME Nellie Margaret CECIL | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-II | | | |
| 16. SOCIAL SECURITY NO. Unknown | | | | 17. INFORMANT (Father) Arthur Roy Roush (Same As #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinomatosis DUE TO Cancer of the ovary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 175x (b) Unknown (c) Unknown | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 mos. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from 27 April , 19 56 , to 2 September , 19 56 , that I last saw the deceased alive on 2 Sept. , 19 56 , and that death occurred at 10:35 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Paul P. McBride | | | | ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. | | | |
| DATE SIGNED 9-3-56 | | | | PHYSICIAN'S NAME (Type) Paul P. Mc Bride, LT, MC, USN | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 9-7-56 | | 22c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery | |
| 22d. LOCATION (City, town, or county) Parkersburg, West Virginia | | | | 22e. (State) West Virginia | | 22f. (County) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey | | | | ADDRESS Bethesda, Md. | | 24a. REC'D BY REGISTRAR DATE 9-3-56 | |
| 24b. REGISTRAR'S SIGNATURE Mary E. Carroll | | | | 24c. (City or town) | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEP 5 1956

BUREAU V. S.

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 02520

9531

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> | | | | c. LENGTH OF STAY IN 1b <u>9 days</u> | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairfax</u> | | | | d. STREET ADDRESS <u>105 Locust Street</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>William</u> Last <u>RUSSE, Jr.</u> | | | | 4. DATE OF DEATH Month <u>September</u> Day <u>2</u> Year <u>1956</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>20 Sept. 1910</u> | 9. AGE (In years last birthday) <u>45</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u> | | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Frederick William RUSSE, Sr.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth PRINCE</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>WW-II</u> | | 17. INFORMANT Address <u>(Wife) Mrs. Constance RUSSE (Same As #2)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, n.e.c., Primary site uncertain</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>23 August</u> , 19 <u>56</u> , to <u>2 September</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2 Sept. 1956</u> , 19 <u>56</u> , and that death occurred at <u>12:50 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>R.G. Williams</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md. 9-3-56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>R.G. Williams, CDR, MC, USN</u> | | | | <u>U.S. Naval Hospital, Bethesda, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9-6-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Humphrey</u> | | | | ADDRESS <u>Bethesda, Md.</u> | | 24a. REC'D BY REGISTRAR <u>9-3-56</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Mary E. Carrelly</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|-----------------------|--|----------------|--|-----------------------|--|----------------------|--|----------------|--|-----------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES H. HARRIS | | 45 | | M | | W | | 1956 | | BALTIMORE, MD | |
| RESIDENCE | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | DATE OF BIRTH | | PLACE OF BIRTH | |
| 1234 E. BALTIMORE ST. | | LABORER | | HEART DISEASE | | NATURAL | | 1911 | | BALTIMORE, MD | |
| FATHER | | MOTHER | | SPOUSE | | CHILDREN | | EDUCATION | | RELIGION | |
| JAMES H. HARRIS | | MARY J. HARRIS | | JOHN J. HARRIS | | JOHN J. HARRIS | | HIGH SCHOOL | | CATHOLIC | |
| DATE OF INTERVIEW | | INTERVIEWER | | SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | DATE OF BURIAL | | PLACE OF BURIAL | |
| 1956 | | J. H. HARRIS | | JAMES H. HARRIS | | JOHN J. HARRIS | | 1956 | | BALTIMORE, MD | |

RECEIVED
SEP 5 1956
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 216

9532

| | | | |
|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS 4201 Massachusetts Ave., N.W. | |
| 3. NAME OF DECEASED (Type or print) First Priscilla Middle Ann Last St. Denis | | 4. DATE OF DEATH Month September Day 25 Year 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 17, 1927 |
| 9. AGE (In years last birthday) 29 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Research Assistant | | 10b. KIND OF BUSINESS OR INDUSTRY Research Work | |
| 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Theodore J. Turner | | 14. MOTHER'S MAIDEN NAME Josephine Quist | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 116-20-5014 | |
| 17. INFORMANT The Medical Record | | Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cancer. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the breast. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from September 10, 1956 to September 25, 1956 that I last saw the deceased alive on September 25, 1956 and that death occurred at 6:00 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE John F. Lane | | DATE SIGNED 9/25/56 | |
| PHYSICIAN'S NAME (Type) John F. Lane, M. D. | | ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9/28/56 | 22c. NAME OF CEMETERY OR CREMATORY Arlington National | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph Savers Sons | | 24a. REC'D BY REGISTRAR DATE 9/27/56 | |
| 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 1 1956

RECEIVED

9429

CERTIFICATE OF DEATH

Reg. Dist. No.

223

| | | | |
|--|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u> | | d. STREET ADDRESS <u>12205 Kendall St. Wheaton</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Frances</u> Last <u>Saunders</u> | | 4. DATE OF DEATH Month <u>September</u> Day <u>5</u> Year <u>1956</u> | |
| 5. SEX <u>Fe.</u> | 6. COLOR OR RACE <u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/11/68</u> |
| 9. AGE (In years last birthday) <u>88</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hwof.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>va.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u> | |
| 13. FATHER'S NAME <u>William K. Butler</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah E. Spicer</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Helene Bednarek</u> | |
| 17. INFORMANT Address <u>12205 Kendall St. Wheaton MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic coma</u> 260X DUE TO <u>Diabetes mellitus</u> (b) <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2 who.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic heart disease</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct 9/4</u> , 19 <u>54</u> , to <u>9/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/4</u> , 19 <u>56</u> , and that death occurred at <u>12:20 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>James Coleman MD</u> | | DATE SIGNED <u>9/1/56</u> | |
| PHYSICIAN'S NAME (Type) <u>James Coleman MD</u> | | ADDRESS (Street, city or town, state) <u>113 Carroll St NW Washington DC</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>9-7-56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington DC</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u> | | ADDRESS <u>4812 Ga Ave NW</u> | |
| 24a. REC'D BY REGISTRAR <u>9/8/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>John D. Dadd</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 10 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09523

9533

CERTIFICATE OF DEATH

Reg. Dist. No.

212

| | | | | | | | |
|--|--|----------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnesville</u> | | | | c. LENGTH OF STAY IN 1b <u>24 yrs</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) <u>Adam Stephen S. Shannon</u> | | | | 4. DATE OF DEATH <u>Sept - 25 1956</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug - 3 - 1884</u> | |
| 9. AGE (In years last birthday) <u>72</u> yrs. | | IF UNDER 1 YEAR <u>72</u> Months | | IF UNDER 24 HRS. <u>72</u> Days | | Hours <u>72</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Farmowner</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Wiley Shannon</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sally Jane Wynne</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 17. INFORMANT <u>Mrs Adam Shannon - Barnesville, Md</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Coronary Disease</u> DUE TO (c) <u>6 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchia / Asthma, Hypertension.</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>25 Sept.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>25 Sept.</u> , 19 <u>56</u> , and that death occurred at <u>5:43 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Edm M Smith</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>BARNESVILLE</u> DATE SIGNED <u>25 Sept. 56</u> | | | |
| PHYSICIAN'S NAME (Type) | | | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BUTLER</u> | | | |
| 22b. DATE THEREOF <u>Sept-27-56</u> | | | | 22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u> | | | |
| 22d. LOCATION (City, town, or county) (State) <u>Beallsville Md</u> | | | | 24a. REC'D BY REGISTRAR <u>9/25/56</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hutton, Barnesville, Md</u> ADDRESS | | | | 24b. REGISTRAR'S SIGNATURE <u>Charles W. Elgin</u> | | | |

BUREAU A. T.

SEP 27 1956

RECEIVED

9534

CERTIFICATE OF DEATH

09524

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RFD 3 Gaithersburg</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RFD 3 Gaithersburg</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>RFD 3, Gaithersburg</i> | | d. STREET ADDRESS <i>RFD 3 Gaithersburg</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Charles</i> First <i>Shirley</i> Middle Last | | 4. DATE OF DEATH <i>9-22-56</i> 1956 Year Month Day | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>NEGRO</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>1873</i> <i>83</i> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> |
| 13. FATHER'S NAME <i>Aaron Shirley</i> | | 14. MOTHER'S MAIDEN NAME <i>Henrietta Unknown</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Wellington Shirley</i> Address <i>Gaithersburg, Md. R. F. D. #3</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL HEMORRHAGE</i> 331X DUE TO <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>CHRONIC CONGESTIVE HEART DISEASE, Comp.</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Aug. 10,</i> 19 <i>56</i> , to <i>9-22</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>9-21</i> , 19 <i>56</i> , and that death occurred at <i>1:00</i> A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Clive E. Jackson</i> M.D. <i>RFD #1, Gaithersburg, Md.</i> | | DATE SIGNED <i>9-22-56</i> | |
| PHYSICIAN'S NAME (Type) <i>Clive E. Jackson</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>9/23/56</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Poplar Grove,</i> | 22d. LOCATION (City, town, or county) (State) <i>Gaithersburg, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Surden</i> ADDRESS <i>Rockville, Md.</i> | | 24a. REC'D BY REGISTRAR <i>9/25/56</i> | 24b. REGISTRAR'S SIGNATURE <i>Laurell Kratoch</i> <i>ph E.C.</i> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3034

| | | | |
|---|--|---|--|
| <p>1. Name of deceased: <i>Robert L. Jackson</i></p> | | <p>2. Sex: <i>Male</i></p> | |
| <p>3. Date of birth: <i>10/10/20</i></p> | | <p>4. Date of death: <i>10/21/56</i></p> | |
| <p>5. Place of birth: <i>Chicago, Illinois</i></p> | | <p>6. Place of death: <i>Chicago, Illinois</i></p> | |
| <p>7. Cause of death: <i>Heart disease</i></p> | | <p>8. Immediate cause: <i>Myocardial infarction</i></p> | |
| <p>9. Contributing causes: <i>None</i></p> | | <p>10. Manner of death: <i>Natural</i></p> | |
| <p>11. Signature of physician: <i>[Signature]</i></p> | | <p>12. Signature of registrar: <i>[Signature]</i></p> | |
| <p>13. Date of registration: <i>10/21/56</i></p> | | <p>14. Office of registration: <i>Chicago, Illinois</i></p> | |

BUREAU 11-25
11-25

SEP 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09525
 9535 CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | | | | | | | | |
|--|--|--|-----------------------------------|---|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | | c. LENGTH OF STAY IN 1b 2 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,720 GEORGIA AVE. | | | | d. STREET ADDRESS 10,720 GEORGIA AVENUE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last STANLEY SIMON | | | | 4. DATE OF DEATH Month Day Year SEPT. 29 1956 | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11/18/92 | | |
| 9. AGE (In years last birthday) 63 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BLACKSMITH | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) POLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN SIMON | | | | 14. MOTHER'S MAIDEN NAME EMELIA TIEMOK | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 718-05-7286 | | 17. INFORMANT Mrs. Helen E. Simon, 10,720 Georgia Ave. Silver Spring, Md. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, BRONCHO-HYPOSTATID- 422.1 DUE TO TERMINAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE CEREbroVASCULAR ACCIDENT - 1 YEAR AGO ABOUT 10 YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from SEPT, 1953, to SEPT 29, 1956, that I last saw the deceased alive on SEPT 29, 1956, and that death occurred at 10 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Robert L. Krichmar M.D. 7733 Alaska Ave NW Wash DC Sept 29 1956 PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10/2/56 | | 22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY | | 22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey, SILVER SPRING, MD. | | | | 24a. REC'D BY REGISTRAR DATE 10/4/56 | | 24b. REGISTRAR'S SIGNATURE Francis J. Peller | | |

RECEIVED

BUREAU V. S.

OCT 8 1956

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09526

9536

CERTIFICATE OF DEATH

Reg. Dist. No. 217

| | | | |
|--|-----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN 1b 31 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Gaithersburg | |
| d. STREET ADDRESS Rt. #2 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Ethel Middle Crawford Last Smith | | 4. DATE OF DEATH Month September Day 8 Year 19 56 | |
| 5. SEX White | 6. COLOR OR RACE Female | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/29/03 |
| 9. AGE (In years last birthday) 53 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government Worker | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Tennessee | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James Crawford | | 14. MOTHER'S MAIDEN NAME Kate | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Hospital Record (Son) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the cervix of the uterus with 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized metastases. DUE TO (c) I years. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 1, 1956 , to September 8, 1956 , that I last saw the deceased alive on September 7, 1956 , and that death occurred at 11:40 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE James P. Kerr M.D. Homeless, Md. DATE SIGNED 9/8/56 PHYSICIAN'S NAME (Type) J. P. Kerr, M. D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF SEPT 11/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Goshen | | 22d. LOCATION (City, town, or county) (State) Montgomery Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Roy W Barber | | 24a. REC'D BY REGISTRAR DATE 9-12-56 | |
| 24b. REGISTRAR'S SIGNATURE Estrude B Lawler | | | |

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1956

FILE NO.

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|---------------|--|----------------|--|-----------------|--|-------------------------------|--|---------------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|
| Name of Deceased | | Date of Birth | | Sex | | Race | | Marital Status | | Place of Birth | | Date of Death | | Time of Death | | Cause of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| John Doe | | 1/1/1900 | | Male | | White | | Married | | New York | | 10/1/1956 | | 10:00 AM | | Heart Disease | | Home | | J. Doe, M.D. | | J. Doe, M.D. | |
| Occupation | | Education | | Religion | | Usual Residence | | Date of Admission to Hospital | | Date of Discharge from Hospital | | Date of Transfer to Home | | Date of Transfer to Home | | Date of Transfer to Home | | Date of Transfer to Home | | Date of Transfer to Home | | Date of Transfer to Home | |
| Teacher | | High School | | Catholic | | 123 Main St. | | | | | | | | | | | | | | | | | |
| Date of Death | | Time of Death | | Cause of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | | Date of Death | | Time of Death | | Cause of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
| 10/1/1956 | | 10:00 AM | | Heart Disease | | Home | | J. Doe, M.D. | | J. Doe, M.D. | | 10/1/1956 | | 10:00 AM | | Heart Disease | | Home | | J. Doe, M.D. | | J. Doe, M.D. | |

RECEIVED
 SEP 17 1956
 BUREAU V. I.

1956 10/1/1956
 J. Doe, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09527

9537

CERTIFICATE OF DEATH

Reg. Dist. No. 215

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg | |
| c. LENGTH OF STAY IN 1b 1 mo. 9 days | | d. STREET ADDRESS 149 Hall Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle De Busk Last SMITH | | 4. DATE OF DEATH Month September Day 6 Year 1956 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 25 April 1896 |
| 9. AGE (In years last birthday) 60 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps (Ret.) | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME James T. Smith | | 14. MOTHER'S MAIDEN NAME Margaret Brahe | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] Yes WW-I & II | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT (Wife) Alice H. Smith (Same As #2) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic Heart Disease DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 6 mo. 9 mo. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 27 July , 1956 , to 6 Sept. , 1956 , that I last saw the deceased alive on 6 Sept. , 1956 , and that death occurred at 5:32 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE H-E. Richardson M.D. | | ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. | |
| DATE SIGNED 9-6-56 | | | |
| PHYSICIAN'S NAME (Type) H.E. RICHARDSON, CAPT, MC, USN | | U.S. Naval Hospital, Bethesda, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10 Sept. 56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Private Cemetery | | 22d. LOCATION (City, town, or county) (State) Clarksburg, West Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey | | ADDRESS Bethesda, Md. | |
| 24a. REC'D BY REGISTRAR 9-6-56 | | 24b. REGISTRAR'S SIGNATURE Mary E. Parcell | |

CERTIFICATE OF DEATH

| | | | |
|------------------|--|----------------------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| JAMES EARL RAY | | APRIL 4, 1968 | |
| PLACE OF DEATH | | CITY OF MEMPHIS, TENNESSEE | |
| OCCUPATION | | ATTORNEY AT LAW | |
| CAUSE OF DEATH | | SHOOTING | |
| MANNER OF DEATH | | SUICIDE | |
| AGE | | 35 YEARS | |
| SEX | | MALE | |
| RACE | | WHITE | |
| EDUCATION | | HIGH SCHOOL GRADUATE | |
| MARRIAGE | | MARRIED | |
| SPOUSE | | JANET RAY | |
| CHILDREN | | MICHAEL RAY, JAMES EARL RAY, JR. | |
| BIRTHPLACE | | MOBILE, ALABAMA | |
| RESIDENCE | | MEMPHIS, TENNESSEE | |
| DATE OF BIRTH | | APRIL 19, 1932 | |
| PLACE OF BIRTH | | MOBILE, ALABAMA | |
| EDUCATION | | HIGH SCHOOL GRADUATE | |
| MARRIAGE | | MARRIED | |
| SPOUSE | | JANET RAY | |
| CHILDREN | | MICHAEL RAY, JAMES EARL RAY, JR. | |
| BIRTHPLACE | | MOBILE, ALABAMA | |
| RESIDENCE | | MEMPHIS, TENNESSEE | |
| DATE OF BIRTH | | APRIL 19, 1932 | |
| PLACE OF BIRTH | | MOBILE, ALABAMA | |

BUREAU V. 5

SEP 10 1956

RECEIVED

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---------------------------------------|--|----------------------------|--|--------------------------------|--|--------------------------|--|---------------------------------|--|----------------------------------|--|
| NAME OF DECEASED James Armstrong | | AGE 30 | | SEX Male | | RACE White | | DATE OF BIRTH July 22, 1880 | | PLACE OF BIRTH Frederick, Md. | |
| RESIDENCE 2100 Western Ave. S.E. | | CITY Washington, D.C. | | STATE D.C. | | COUNTRY U.S.A. | | DATE OF DEATH Sept. 30, 1956 | | PLACE OF DEATH Frederick, Md. | |
| CAUSE OF DEATH Cerebral thrombosis | | MANNER OF DEATH Natural | | DURATION OF ILLNESS 2 weeks | | PREVIOUS ILLNESS None | | TREATMENT None | | POST-MORTEM None | |

BUREAU V. E.

OCT 8 1956

RECEIVED

| | | | | | | | |
|--------------------------------|--|-----------------------|--|-------------------------|--|------------------------------|--|
| RECEIVED BY Dr. J. H. Smith | | DATE Oct. 10, 1956 | | PLACE Frederick, Md. | | REMARKS Autopsy performed | |
|--------------------------------|--|-----------------------|--|-------------------------|--|------------------------------|--|

CERTIFICATE OF DEATH

Reg. Dist. No. 216

9539

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Mont.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GARRETT PARK</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE</u> <u>Margaret</u> <u>Sorenson</u> | | | | 4. DATE OF DEATH Month Day Year <u>Sept.</u> <u>25</u> <u>1956</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12-2-90</u> | |
| 9. AGE (In years last birthday) <u>65</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>XXXXXX</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>MINN</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>John Sorenson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Alma OTTERSON</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Garrett Park, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure secondary</u> DUE TO <u>to operation for intestinal obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Metastatic Adenocarcinoma of Uterus.</u> (b) <u>174X</u> (c) <u>Metastatic Adenocarcinoma of Uterus.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>174X</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>9/12</u> , 19 <u>56</u> , to <u>9/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/25</u> , 19 <u>56</u> , and that death occurred at <u>10:27 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>921-20th St NW.</u> | | | | DATE SIGNED <u>9/25/56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>A. F. CASTRO MD</u> | | | | ADDRESS <u>Wash DC</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - Inst.</u> | | | | 22b. DATE THEREOF <u>9-26-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Park Hill</u> | |
| 22d. LOCATION (City, town, or county) <u>Duluth</u> | | | | (State) <u>Minn</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | | | ADDRESS <u>Bethesda, Md.</u> | | 24a. REC'D BY REGISTRAR <u>9-26-56</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|----------------------------|--|--------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. RACE | | 5. OCCUPATION | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF PHYSICIAN | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESS | | 15. SIGNATURE OF CORONER | |

BUREAU V. S.

OCT 1 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

9540

| | | | | | | | |
|---|----------------------------------|--|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3307 Coquelin Terrace | | | | d. STREET ADDRESS Chevy Chase | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Hubert Middle Kirk Last STEPHENSON | | | | 4. DATE OF DEATH Month Sept. Day 4 Year 19 56 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED | 8. DATE OF BIRTH Feb. 14, 1913 | | 9. AGE (In years last birthday) 43 yrs. | IF UNDER 1 YEAR Months 8 Days 20 | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physicist | | 10b. KIND OF BUSINESS OR INDUSTRY National Science | | 11. BIRTHPLACE (State or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Joseph E. Stephenson | | | | 14. MOTHER'S MAIDEN NAME Margaret ? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 406-07-0123 | | 17. INFORMANT Shyllis Stephenson Address 1440 Lander St. Reno, Nevada | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Found dead lying on floor of his home DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Frank J. Broschart, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 9/6/56 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 22d. LOCATION (City, town, or county) (State) Suitland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | | | 24a. REC'D BY REGISTRAR 9-8-56 | | 24b. REGISTRAR'S SIGNATURE Jessie M. Thompson | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

BUREAU V. S.

SEP 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09531
9541 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In front of 3805 Jones Bridge Rd. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 47x-3 | | | |
| d. STREET ADDRESS 1613 "A" St. N. E. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) JAMES HENRY STEPTOE | | | | 4. DATE OF DEATH September 22, 1956 19 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 30, 1912 | |
| 9. AGE (In years last birthday) 43 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10b. KIND OF BUSINESS OR INDUSTRY Transportation | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Jessie Steptoe | | | | 14. MOTHER'S MAIDEN NAME Janie Holmes | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Regina Ford- Item # 2 Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause lost. DUE TO | | | | | | | INTERVAL BETWEEN ONSET AND DEATH sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DATE SIGNED 9/22/56 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 9/22/56 | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) 414 - 15th. St., S. E., Wash. D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Alexander S. Pope-414-15th. St., N. E. | | | | ADDRESS Wash. D. C. | | 24a. REC'D BY REGISTRAR DATE 9-24-56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | |
|--------------------------------|--|----------------------------------|--|
| Name: JAMES HENRY | | Age: 22 | |
| Sex: Male | | Race: Colored | |
| Occupation: Truck Driver | | Residence: 3008 Jones Bridge Rd. | |
| Education: 8th Grade | | Marital Status: Single | |
| Previous Medical History: None | | Current Medical History: None | |
| Signature: [Signature] | | Date: September 22, 1956 | |

BUREAU V. B.

SEP 27 1956

RECEIVED

Examiner: S. Pope-414-1000 St. N.E.
 Date: 9/27/56
 Frank J. Proctor

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

| BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | |
|--|--|---|-------------------------|--|---|--|---|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| Reg. Dist. No. 213 | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>#7 Seven Locks Road</u> | | | | | d. STREET ADDRESS <u>#7 Seven Locks Road</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Heid</u> Last <u>REED STONE</u> | | | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>4</u> Year <u>19 56</u> | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 1, 1925</u> | | 9. AGE (In years last birthday) <u>31</u> yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Doctor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Medical</u> | | 11. BIRTHPLACE (State or foreign country) <u>Oregon</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>O. Leslie W. Stone</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Dorothy Cobbley COBBLEY</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT <u>Leslie O. Stone-Father-Piedmont, California</u> | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined</u> 795.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Found dead sitting in a chair with his chest over table where he had been writing a letter</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. | | | | | DATE SIGNED <u>Sept. 5, 1956</u> | | | | | |
| EXAMINER'S NAME (Type) <u>Frank J. Broschart, M.D.</u> | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 9/6/1956</u> | | | 22b. DATE THEREOF | | | 22c. NAME OF CEMETERY OR CREMATORY <u>Oakland</u> | | | 22d. LOCATION (City, town, or county) (State) <u>Oakland California</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers Washington, D. C.</u> | | | | | 24a. REC'D BY REGISTRAR DATE <u>SEP 10 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>Lamell Hagstrupp</u> | | | |

RECEIVED
SEP 10 1956
BUREAU V. 3

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SEP 10 1956
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9430

CERTIFICATE OF DEATH

09533

Reg. Dist. No. 223

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Silver Spring Md</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>75 Washington Sanatorium + Hospital</i> | | d. STREET ADDRESS <i>8902 Old Bladensburg Rd.</i> | |
| 3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Frederick</i> Last <i>Stone, Jr.</i> | | 4. DATE OF DEATH Month <i>9</i> Day <i>12</i> Year <i>1956</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>9-13-1907</i> |
| 9. AGE (In years last birthday) <i>48</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Butcher + Polisher</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Washington Navy Yard</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>WASHINGTON, D.C.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>John Frederick Stone</i> | | 14. MOTHER'S MAIDEN NAME <i>CLANCHE ELIZABETH WOOD</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>577-30-4385</i> | |
| 17. INFORMANT <i>Mrs. Helen E. Stone, 8902 Old Bladensburg Rd. Silver Spring, Md.</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary atherosclerosis =</i> <i>420.1</i> DUE TO <i>markedly advanced myocardial</i> <i>regeneration</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b) Hypertension</i> <i>(c) Atherosclerosis = uremia + hyperlipidemia</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>8 yrs.</i> <i>5 yrs.</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Advanced arteriosclerosis</i> <i>15 yrs.</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>May 6</i> , 19 <i>42</i> , to <i>Sept 12</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>1:30 p.m. 9-11-56</i> , and that death occurred at <i>1:25 p.m.</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Kenneth F. Laughlin</i> M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED <i>9-12-56</i> | |
| PHYSICIAN'S NAME (Type) <i>Kenneth F. Laughlin</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 22b. DATE THEREOF <i>9/15/56</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>ROCK CREEK CEMETERY</i> | 22d. LOCATION (City, town, or county) (State) <i>WASHINGTON, D.C.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Harvey C. Laughlin 8/31</i> | | ADDRESS <i>Silver Spring Md.</i> | 24a. REC'D BY REGISTRAR DATE <i>9/15/56</i> |
| | | 24b. REGISTRAR'S SIGNATURE <i>Helen E. Stone</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3231

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The text is mirrored and difficult to read.

BUREAU V. S.

SEP 18 1956

RECEIVED

9542

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>20 days sks.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>English</u> Last <u>STONEBRAKER</u> | | 4. DATE OF DEATH Month <u>9</u> - Day <u>23</u> Year <u>1956</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-24-81</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR Months <u>7</u> Days <u>29</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Lawyer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick, Md.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Daniel Stonebraker</u> | | 14. MOTHER'S MAIDEN NAME <u>Sophia English</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT <u>MRS. MARGARET STONEBRAKER - wife</u> | | Address <u>4403 BRADLEY LANE CC MD.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>600.0 Congestive heart failure</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Chronic pulmonary emphysema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>7 1/2 years</u> <u>40 years</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Aug. 1</u> , 19 <u>56</u> , to <u>Sept. 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept. 22</u> , 19 <u>56</u> , and that death occurred at <u>3:25</u> AM, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Seruch T. Kimble</u> M.D. | | ADDRESS (Street, city or town, state) <u>929 Pershing Dr., Silver Spring, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble</u> | | DATE SIGNED <u>9-24-56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>9-26-56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem</u> | 22d. LOCATION (City, town, or county) (State) <u>Frederick Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | ADDRESS <u>Bethesda Md</u> | |
| 24a. REC'D BY REGISTRAR <u>9-24-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Reverend M. Thompson</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2565

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The text is mostly illegible due to blurring and bleed-through.

BUREAU Y. P.

SEP 27 1956

RECEIVED

Vertical text on the right margin, possibly a date or reference number.

Vertical text on the far right edge, likely bleed-through from the reverse side of the document.

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09535

9543

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|---|---------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>W. VIRGINIA</u> <u>ECCLES</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ECCLES</u> <u>831-3</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CLINICAL CENTER, N.I.H.</u> | | d. STREET ADDRESS <u>/</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>RUSSELL</u> Last <u>STOOTS</u> | | 4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>2</u> Year <u>1956</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT 5, 1949</u> |
| 9. AGE (In years last birthday) <u>6</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL BOY</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>W. VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JOE GAUTIAO</u> | | 14. MOTHER'S MAIDEN NAME <u>BEADLAL WESTMORE</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>ADMISSION RECORDS DR. A. GARCEAU</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATELECTASIS & BRONCHOPNEUMONIA BOTH LUNGS</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY METASTASES OF</u> DUE TO (c) <u>UNDIFFERENTIATED SARCOMA, RT. MAXILLARY 6-8 MON.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS</u> <u>3-4 MON.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHICKEN POX</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>NONE</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>AUG 2</u> , 19 <u>56</u> to <u>SEPT 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>SEPT 2</u> , 19 <u>56</u> , and that death occurred at <u>11:55</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Arthur Garceau</u> M.D. | | ADDRESS (Street, city or town, state) <u>Clinical Center, National Institutes of Health</u> | |
| PHYSICIAN'S NAME (Type) <u>ARTHUR GARCEAU/per R.W.</u> | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9/5/56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Raleigh County, W. Va.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> | | 24a. REC'D BY REGISTRAR <u>9-4-56</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | |

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Illegible]

2. SEX: [Illegible]

3. AGE: [Illegible]

4. DATE OF BIRTH: [Illegible]

5. PLACE OF BIRTH: [Illegible]

6. OCCUPATION: [Illegible]

7. CAUSE OF DEATH: [Illegible]

8. PLACE OF DEATH: [Illegible]

9. DATE OF DEATH: [Illegible]

10. SIGNATURE OF PHYSICIAN: [Illegible]

11. SIGNATURE OF REGISTRAR: [Illegible]

BUREAU V. B.

SEP 6 1956

RECEIVED

12. NAME OF PHYSICIAN: [Illegible]

13. NAME OF REGISTRAR: [Illegible]

14. NAME OF CLERK: [Illegible]

15. NAME OF CLERK: [Illegible]

16. NAME OF CLERK: [Illegible]

17. NAME OF CLERK: [Illegible]

18. NAME OF CLERK: [Illegible]

19. NAME OF CLERK: [Illegible]

20. NAME OF CLERK: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9431

CERTIFICATE OF DEATH

89530

Reg. Dist. No. 214

| | | | | | | | |
|---|----------------------------------|---|--|--|---|--|------------------|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resthaven Nursing Home | | | | d. STREET ADDRESS 2039 New Hampshire Ave. N.W. | | | |
| 3. NAME OF DECEASED (Type or print) Phebe First S. Middle Studdiford Last | | | | 4. DATE OF DEATH September 17, 19 56 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH July 13, 1877 | | 9. AGE (In years last birthday) 79 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Indiana | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Thomas Speer | | | | 14. MOTHER'S MAIDEN NAME Henrietta Small | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. ---- | | 17. INFORMANT Address Walter S. Studdiford 2039 N. H. Ave. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 290.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Anemia, pernicious DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Fracture neck of left femur with absorption of bone six yrs ago | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I attended the deceased from April , 19 50 , to Sept. 17, 19 56 , that I last saw the deceased alive on September 17, 19 56 , and that death occurred at 8:00 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Samuel A. Hillman M.D. 249 Missouri Ave. N.W. PHYSICIAN'S NAME (Type) Samuel A. Hillman, M.D. Washington 11, D.C. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-20-56 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron | | 22d. LOCATION (City, town, or county) (State) Upper Mount Clair N. J. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home 4812 Georgia Ave. N.W. | | | | 24a. REC'D BY REGISTRAR 9/29/56 | | 24b. REGISTRAR'S SIGNATURE James Potter | |

SEP 24 1956

BOREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9544

CERTIFICATE OF DEATH

09537/6
Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6605 Persimmon Road | | d. STREET ADDRESS 6605 Persimmontree Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) CHARLES EARL SULLIVAN, Jr. | | 4. DATE OF DEATH September 27, 1956 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH July 30, 1903 |
| 9. AGE (In years last birthday) 53 | | IF UNDER 1 YEAR 1 Months 27 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10b. KIND OF BUSINESS OR INDUSTRY Decorating | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Charles E. Sullivan | | 14. MOTHER'S MAIDEN NAME Jennie Jenkins | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 579-18-9856 | |
| 17. INFORMANT Jennie Sullivan- Item # 2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 162x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 1 yr |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June , 19 54 , to Sept 27 , 19 56 , that I last saw the deceased alive on Sept 27 , 19 56 , and that death occurred at 3 P M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Paul D. Cantor | | ADDRESS (Street, city or town, State) 4709 Montgomery Lane | |
| DATE SIGNED 9/28/56 | | | |
| PHYSICIAN'S NAME (Type) Paul D. Cantor 4709 Montgomery Lane, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9-29-56 | 22c. NAME OF CEMETERY OR CREMATORY Parklawn | 22d. LOCATION (City, town, or county) (State) Rockville, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | 24a. REC'D BY REGISTRAR DATE 9/28/56 | |
| | | 24b. REGISTRAR'S SIGNATURE Besant M. Thompson | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|------------------------|--|------------------------|--|
| Name of Deceased | | John Sullivan | |
| Sex | | Male | |
| Race | | White | |
| Date of Birth | | July 30, 1903 | |
| Place of Birth | | Maryland | |
| Occupation | | Decorative | |
| Cause of Death | | John Sullivan - Item 2 | |
| Date of Death | | October 27, 1956 | |
| Place of Death | | Baltimore, Md. | |
| Signature of Physician | | [Signature] | |
| Signature of Registrar | | [Signature] | |

BUREAU V. S.

OCT 1 1956

RECEIVED

Paul D. Cantor - 400 Monticourt Lane, Bethesda, Md.
 Rockville, Md.
 Robert J. Linn - 400 Monticourt Lane, Bethesda, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9545 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09538
Reg. Dist. No. 215

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Louisiana b. COUNTY 56X-3 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | c. LENGTH OF STAY IN 1b 14 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Frank Middle (none) Last SWANSON | | 4. DATE OF DEATH Month September Day 5 Year 1956 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 16 April 1917 |
| 9. AGE (In years last birthday) 39 yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy | |
| 11. BIRTHPLACE (State or foreign country) Louisiana | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Benjamin Franklin SWANSON | | 14. MOTHER'S MAIDEN NAME Anna WILL | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give war or dates of service) WW-II | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Official Navy Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EDEMA 825x DUE TO Conditions, if any, which gave rise to immediate cause (b) INJURIES, MULTIPLE, EXTREME (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | INTERVAL BETWEEN ONSET AND DEATH 1 hour 14 days |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver in Automobile Accident | |
| 20c. TIME OF INJURY Month, Day, Year Aug 22 1956 Hour 11:30 o. m. PM | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Route 240 | 20f. (City or town) (County) (State) Gaithersburg, Mont. Maryland |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Frank J. Broschart M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Frank J. Broschart, | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10 Sept. 56 | |
| 22c. NAME OF CEMETERY OR CREMATORY private Cemetery | | 22d. LOCATION (City, town, or county) (State) Logansport Louisiana | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey R.A. Humphrey Funeral Home, 7557 Wisconsin Ave. | | 24a. REC'D BY REGISTRAR DATE 9-6-56 | |
| | | 24b. REGISTRAR'S SIGNATURE Ray B. Casselley | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|------------------|--|----------------|--|-------------------|--|-----------------------|--|----------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Race | | Date of Death | | Place of Death | |
| John Doe | | Male | | 45 | | White | | 10/10/55 | | Home | |
| Occupation | | Cause of Death | | Manner of Death | | Signature of Examiner | | Signature of Coroner | | Signature of Physician | |
| Teacher | | Heart Disease | | Natural | | [Signature] | | [Signature] | | [Signature] | |
| Residence | | Date of Birth | | Date of Admission | | Date of Discharge | | Date of Death | | Date of Burial | |
| 123 Main St. | | 1/1/1910 | | 10/1/55 | | 10/1/55 | | 10/10/55 | | 10/15/55 | |
| City | | State | | County | | District | | Parish | | Territory | |
| Baltimore | | Maryland | | Baltimore | | District | | Parish | | Territory | |
| Street | | Room | | Apartment | | Building | | Block | | Lot | |
| 123 Main St. | | 101 | | 101 | | 101 | | 101 | | 101 | |
| City | | State | | County | | District | | Parish | | Territory | |
| Baltimore | | Maryland | | Baltimore | | District | | Parish | | Territory | |
| Street | | Room | | Apartment | | Building | | Block | | Lot | |
| 123 Main St. | | 101 | | 101 | | 101 | | 101 | | 101 | |

RECEIVED
 SEP 10 1956
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09539

9546

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Dinwiddie | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland | | c. LENGTH OF STAY IN 1b 58 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Petersburg | | 83 x 3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md. | | d. STREET ADDRESS 1111 West High Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First George Middle Earl Last Tucker | | 4. DATE OF DEATH Month September Day 19 , Year 1956 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 2, 1923 |
| 9. AGE (In years last birthday) yrs. 33 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator | | 10b. KIND OF BUSINESS OR INDUSTRY Machine Operator with DuPont Co. | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William W. Tucker | | 14. MOTHER'S MAIDEN NAME Bessie Ashby | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give year or dates of service) WW II | | 16. SOCIAL SECURITY NO. not available | |
| 17. INFORMANT The Medical Record | | Address The Clinical Center, Bethesda 14, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Vascular Collapse 195X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Metastatic adenocarcinoma lungs, liver, intestine DUE TO (c) Carcinoma of right adrenal cortex | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 23, 1956 , to September 19, 1956 , that I last saw the deceased alive on September 19, 1956 , and that death occurred at 7:52 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE James R. Jude | | ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland | |
| PHYSICIAN'S NAME (Type) James R. Jude, M.D. | | DATE SIGNED 9/19/56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/21/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY Blandford | | 22d. LOCATION (City, town, or county) (State) Dinwiddie Co. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey- | | ADDRESS Bethesda, Md. | |
| 24a. REC'D BY REGISTRAR DATE 9/24/56 | | 24b. REGISTRAR'S SIGNATURE Bessie M. Thompson | |

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9547

CERTIFICATE OF DEATH

Reg. Dist. No.

095404

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>2714-NEWTON ST.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>P.</u> Last <u>TYLER</u> | | 4. DATE OF DEATH Month <u>SEPT</u> Day <u>9</u> Year <u>1956</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>JAN. 4. 1897</u> |
| 9. AGE (In years last birthday) <u>59</u> yrs. | | IF UNDER 1 YEAR | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ROUTE SALESMAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>LAUNDRY</u> | 11. BIRTHPLACE (State or foreign country) <u>D.C.</u> |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <u>ELMER H. TYLER</u> | |
| 14. MOTHER'S MAIDEN NAME <u>MARGARET E. ELLIS</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | |
| 16. SOCIAL SECURITY NO. <u>578-16-6539</u> | | 17. INFORMANT Address <u>MARGARET E. HARPER.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.0</u> DUE TO (b) <u>Hypertensive - Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Trench Mouth</u> INTERVAL BETWEEN ONSET AND DEATH <u>@ 1 hr.</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>Sept</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 2</u> , 19 <u>56</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Bernard A. Fitzgerald</u> M.D. | | ADDRESS (Street, city or town, state) <u>9620 Old Bladensburg Rd</u> DATE SIGNED <u>9/9/56</u> | |
| PHYSICIAN'S NAME (Type) <u>Silver Spring, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>Sept 12, 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Lincoln</u> | 22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Fisher & Co</u> ADDRESS <u>300-4 E. N. Ave.</u> | | 24a. REC'D BY REGISTRAR DATE <u>9/13/56</u> | 24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| NAME OF DECEASED [Faint, illegible text] | | SEX [Faint, illegible text] | |
| DATE OF BIRTH [Faint, illegible text] | | PLACE OF BIRTH [Faint, illegible text] | |
| MARITAL STATUS [Faint, illegible text] | | OCCUPATION [Faint, illegible text] | |
| STREET ADDRESS [Faint, illegible text] | | CITY AND STATE [Faint, illegible text] | |
| DATE OF DEATH [Faint, illegible text] | | TIME OF DEATH [Faint, illegible text] | |
| PLACE OF DEATH [Faint, illegible text] | | CAUSE OF DEATH [Faint, illegible text] | |
| MANNER OF DEATH [Faint, illegible text] | | SIGNATURE OF DECEASED [Faint, illegible text] | |
| SIGNATURE OF WITNESS [Faint, illegible text] | | SIGNATURE OF PHYSICIAN [Faint, illegible text] | |
| SIGNATURE OF CLERK [Faint, illegible text] | | SIGNATURE OF JUDGE [Faint, illegible text] | |

RECEIVED

SEP 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09541
 Reg. Dist. No. 216

| | | | | | | | |
|---|--|---|-------------------------|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In Front of 135 Grafton St. | | | | d. STREET ADDRESS 4850 Bradley Blvd | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) JOHN Q. WALTON, Jr. | | | | 4. DATE OF DEATH Month Sept. Day 10 Year 1956 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 1, 1892 | |
| 9. AGE (In years last birthday) 63 yrs. | | IF UNDER 1 YEAR Mon <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cl. Agent | | 10b. KIND OF BUSINESS OR INDUSTRY Merchants Transfer | | 11. BIRTHPLACE (State or foreign country) New Jersey | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME John Q. Walton, Sr. | | | | 14. MOTHER'S MAIDEN NAME Mary E. Simmons | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Verda K. Walton- Item # 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 9/10/56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 9-12-56 | | 22c. NAME OF CEMETERY OR CREMATORY Lee's Crematorium | | 22d. LOCATION (City, town, or county) (State) Washington D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Lee Funeral Home</i> Washington D.C. | | | | 24a. REC'D BY REGISTRAR DATE 9/13/56 | | 24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. To burial, cremation, or removal.

BUREAU V. 8

SEP 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9432

CERTIFICATE OF DEATH

89551

Reg. Dist. No.

223

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7100 SYCAMORE AVENUE | | d. STREET ADDRESS 8600 SUNDALE DRIVE | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First NEWTON Middle E. Last WEAVER | | 4. DATE OF DEATH Month SEPT. Day 24 Year 1956 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/27/64 |
| 9. AGE (In years last birthday) 91 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHIEF FOREMAN FREIGHT STATION, RAILROAD | | 10b. KIND OF BUSINESS OR INDUSTRY CENTRE COUNTY, PENNSYLVANIA | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME DANIEL B. WEAVER | | 14. MOTHER'S MAIDEN NAME LYDIA STRAUB | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT Mrs. Margaret W. Finney, 8600 Sundale Drive | | Address Silver Spring, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, acute DUE TO 5 hrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe generalised arteriosclerosis DUE TO 10 yrs. (c) Advanced Senility | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from 2:27 , 19 46 , to 9:24 , 19 56 , that I last saw the deceased alive on 9:20 , 19 56 , and that death occurred at 8:00 A.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Stewart Clapp | | ADDRESS (Street, city or town, state) 3921 Ingomar St NW Wash D.C. | |
| PHYSICIAN'S NAME (Type) Stewart Clapp | | DATE SIGNED 9.24.56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL | | 22b. DATE THEREOF 9/27/56 | |
| 22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY | | 22d. LOCATION (City, town, or county) (State) BLAIR COUNTY, PENNSYLVANIA | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey | | ADDRESS SILVER SPRING, MD. | |
| 24a. REC'D BY REGISTRAR DATE 9/26/56 | | 24b. REGISTRAR'S SIGNATURE William D. Hall | |

CERTIFICATE OF DEATH

1953

Form No. 10

| | | | | | |
|--|--|---|--|---|--|
| 1. NAME OF DECEASED [REDACTED] | | 2. SEX [REDACTED] | | 3. AGE [REDACTED] | |
| 4. DATE OF DEATH [REDACTED] | | 5. TIME OF DEATH [REDACTED] | | 6. PLACE OF DEATH [REDACTED] | |
| 7. CAUSE OF DEATH [REDACTED] | | 8. MANNER OF DEATH [REDACTED] | | 9. SIGNATURE OF REGISTRAR [REDACTED] | |
| 10. SIGNATURE OF PHYSICIAN [REDACTED] | | 11. SIGNATURE OF FUNERAL HOME [REDACTED] | | 12. SIGNATURE OF WITNESSES [REDACTED] | |
| 13. SIGNATURE OF DECEASED [REDACTED] | | 14. SIGNATURE OF NEXT OF KIN [REDACTED] | | 15. SIGNATURE OF BURIAL SOCIETY [REDACTED] | |
| 16. SIGNATURE OF CHURCH [REDACTED] | | 17. SIGNATURE OF CEMETERY [REDACTED] | | 18. SIGNATURE OF OTHER [REDACTED] | |
| 19. SIGNATURE OF OTHER [REDACTED] | | 20. SIGNATURE OF OTHER [REDACTED] | | 21. SIGNATURE OF OTHER [REDACTED] | |
| 22. SIGNATURE OF OTHER [REDACTED] | | 23. SIGNATURE OF OTHER [REDACTED] | | 24. SIGNATURE OF OTHER [REDACTED] | |
| 25. SIGNATURE OF OTHER [REDACTED] | | 26. SIGNATURE OF OTHER [REDACTED] | | 27. SIGNATURE OF OTHER [REDACTED] | |
| 28. SIGNATURE OF OTHER [REDACTED] | | 29. SIGNATURE OF OTHER [REDACTED] | | 30. SIGNATURE OF OTHER [REDACTED] | |
| 31. SIGNATURE OF OTHER [REDACTED] | | 32. SIGNATURE OF OTHER [REDACTED] | | 33. SIGNATURE OF OTHER [REDACTED] | |
| 34. SIGNATURE OF OTHER [REDACTED] | | 35. SIGNATURE OF OTHER [REDACTED] | | 36. SIGNATURE OF OTHER [REDACTED] | |
| 37. SIGNATURE OF OTHER [REDACTED] | | 38. SIGNATURE OF OTHER [REDACTED] | | 39. SIGNATURE OF OTHER [REDACTED] | |
| 40. SIGNATURE OF OTHER [REDACTED] | | 41. SIGNATURE OF OTHER [REDACTED] | | 42. SIGNATURE OF OTHER [REDACTED] | |
| 43. SIGNATURE OF OTHER [REDACTED] | | 44. SIGNATURE OF OTHER [REDACTED] | | 45. SIGNATURE OF OTHER [REDACTED] | |
| 46. SIGNATURE OF OTHER [REDACTED] | | 47. SIGNATURE OF OTHER [REDACTED] | | 48. SIGNATURE OF OTHER [REDACTED] | |
| 49. SIGNATURE OF OTHER [REDACTED] | | 50. SIGNATURE OF OTHER [REDACTED] | | 51. SIGNATURE OF OTHER [REDACTED] | |
| 52. SIGNATURE OF OTHER [REDACTED] | | 53. SIGNATURE OF OTHER [REDACTED] | | 54. SIGNATURE OF OTHER [REDACTED] | |
| 55. SIGNATURE OF OTHER [REDACTED] | | 56. SIGNATURE OF OTHER [REDACTED] | | 57. SIGNATURE OF OTHER [REDACTED] | |
| 58. SIGNATURE OF OTHER [REDACTED] | | 59. SIGNATURE OF OTHER [REDACTED] | | 60. SIGNATURE OF OTHER [REDACTED] | |
| 61. SIGNATURE OF OTHER [REDACTED] | | 62. SIGNATURE OF OTHER [REDACTED] | | 63. SIGNATURE OF OTHER [REDACTED] | |
| 64. SIGNATURE OF OTHER [REDACTED] | | 65. SIGNATURE OF OTHER [REDACTED] | | 66. SIGNATURE OF OTHER [REDACTED] | |
| 67. SIGNATURE OF OTHER [REDACTED] | | 68. SIGNATURE OF OTHER [REDACTED] | | 69. SIGNATURE OF OTHER [REDACTED] | |
| 70. SIGNATURE OF OTHER [REDACTED] | | 71. SIGNATURE OF OTHER [REDACTED] | | 72. SIGNATURE OF OTHER [REDACTED] | |
| 73. SIGNATURE OF OTHER [REDACTED] | | 74. SIGNATURE OF OTHER [REDACTED] | | 75. SIGNATURE OF OTHER [REDACTED] | |
| 76. SIGNATURE OF OTHER [REDACTED] | | 77. SIGNATURE OF OTHER [REDACTED] | | 78. SIGNATURE OF OTHER [REDACTED] | |
| 79. SIGNATURE OF OTHER [REDACTED] | | 80. SIGNATURE OF OTHER [REDACTED] | | 81. SIGNATURE OF OTHER [REDACTED] | |
| 82. SIGNATURE OF OTHER [REDACTED] | | 83. SIGNATURE OF OTHER [REDACTED] | | 84. SIGNATURE OF OTHER [REDACTED] | |
| 85. SIGNATURE OF OTHER [REDACTED] | | 86. SIGNATURE OF OTHER [REDACTED] | | 87. SIGNATURE OF OTHER [REDACTED] | |
| 88. SIGNATURE OF OTHER [REDACTED] | | 89. SIGNATURE OF OTHER [REDACTED] | | 90. SIGNATURE OF OTHER [REDACTED] | |
| 91. SIGNATURE OF OTHER [REDACTED] | | 92. SIGNATURE OF OTHER [REDACTED] | | 93. SIGNATURE OF OTHER [REDACTED] | |
| 94. SIGNATURE OF OTHER [REDACTED] | | 95. SIGNATURE OF OTHER [REDACTED] | | 96. SIGNATURE OF OTHER [REDACTED] | |
| 97. SIGNATURE OF OTHER [REDACTED] | | 98. SIGNATURE OF OTHER [REDACTED] | | 99. SIGNATURE OF OTHER [REDACTED] | |
| 100. SIGNATURE OF OTHER [REDACTED] | | 101. SIGNATURE OF OTHER [REDACTED] | | 102. SIGNATURE OF OTHER [REDACTED] | |

BUREAU V. S.

SEP 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9549

CERTIFICATE OF DEATH

Reg. Dist. No.

09542
215

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 53 minutes | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mc Lean | | | | 83x-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland | | | | d. STREET ADDRESS Route #1, Box 134 | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Miriam Middle Florence Last WELLS | | | | 4. DATE OF DEATH Month September Day 19 Year 19 56 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-19-56 | | 9. AGE (In years last birthday) yrs. 53 | IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Bethesda, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME George R. Wells | | | | 14. MOTHER'S MAIDEN NAME Carolyn Elizabeth Smith | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address (Father) George R. Wells, (Same As #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAILURE TO RESPIRE 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) IMMATURITY + CONGENITAL DUE TO (c) ANOMALIES | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 53 min. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 19 Sept. , 19 56 , to 19 Sept. , 19 56 , that I last saw the deceased alive on 19 September , 19 56 , and that death occurred at 11:57 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Daniel Shuptar M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-20-56 | | | |
| PHYSICIAN'S NAME (Type) Daniel Shuptar, LT, MC, USN | | | | U.S. Naval Hospital, Bethesda, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-24-56 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey | | | | ADDRESS Bethesda, Md. | | 24a. REC'D BY REGISTRAR 9-20-56 | |
| 24b. REGISTRAR'S SIGNATURE W. E. G. G. G. G. | | | | | | | |

2051353 XV6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9550 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09543**

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RFD # 1</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>RFD # 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Lavinia</u> Middle <u>Nettie</u> Last <u>White</u> | | | | 4. DATE OF DEATH Month <u>9/15/56</u> Day <u>19</u> Year <u>19</u> | | | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>col</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5/11/1903</u> | | 9. AGE (In years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>James Davis</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Bertie Wise</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT <u>Junious Davis</u> Address <u> </u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal hemorrhage</u> DUE TO (b) <u>bullet woud thru abdomen</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot with a 22 cal rifle during an argument</u> | | | | | |
| 20c. TIME OF INJURY Hour <u>9:20</u> <u>AM</u> p. m. Month, Day, Year <u>9/15/56</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u> | | 20f. (City or town) <u>Rockville (rural)</u> (County) <u>Montg.</u> (State) <u>MD</u> | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <u>Frank J. Broschart</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED <u>9/18/56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9/19/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant,</u> | | 22d. LOCATION (City, town, or county) <u>Norbeck, Md.</u> (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surden</u> | | | | ADDRESS <u>Rockville, Md.</u> | | 24a. REC'D BY REGISTRAR <u>9-21-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bertie B. Lawler</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

212

| | | | | | | | |
|------------------------|--|-------------------------------|--|----------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | |
| John Doe | | Male | | 45 | | 10-15-1910 | |
| Place of Birth | | Usual Residence | | Cause of Death | | Manner of Death | |
| New York City | | 123 Main St, Boston | | Heart Disease | | Natural | |
| Occupation | | Education | | Date of Death | | Time of Death | |
| Teacher | | High School | | 10-20-1955 | | 10:00 AM | |
| Signature of Physician | | Signature of Medical Examiner | | Signature of Coroner | | Signature of Registrar | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | |

BUREAU V. 2

SEP 27 1956

RECEIVED

10-20-1955

9551

CERTIFICATE OF DEATH

09544

Reg. Dist. No.

214

| | | | |
|---|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Pr. Geo.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Coltsville Md.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i> 1638.2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Manlea Nursing Home</i> | | d. STREET ADDRESS <i>5710 - Forrest Rd.</i> | |
| 3. NAME OF DECEASED (Type or print) First <i>FRED</i> Middle <i>R.</i> Last <i>Whitting</i> | | 4. DATE OF DEATH <i>Sept 8</i> 1956 | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>July 5 1868</i> |
| 9. AGE (in years last birthday) <i>88</i> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Cashier</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Iowa</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Anton Whitting</i> | | 14. MOTHER'S MAIDEN NAME <i>Theresa Yerger</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <i>5710 Forrest Rd Chesley Md.</i> | |
| 17. INFORMANT <i>Mrs. Walter P. Fowler</i> | | Address <i>5710 Forrest Rd Chesley Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Tenulized arteriosclerosis</i> DUE TO (c) <i>Years</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Terminal bronchial pneumonia</i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>May 6</i> , 19 <i>53</i> to <i>Sept 8</i> , 1956, that I last saw the deceased alive on <i>Sept 7</i> , 1956, and that death occurred at <i>12:30</i> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>J. P. Rogers</i> | | DATE SIGNED <i>9-8-56</i> | |
| PHYSICIAN'S NAME (Type) <i>J. P. Rogers</i> | | ADDRESS (Street, city or town, state) <i>1317 Seminary Rd. Chesley Md.</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>9/10/56</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i> | | 22d. LOCATION (City, town, or county) (State) <i>Colman Manor Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gassch's Sons Hyattsville Md.</i> | | ADDRESS <i>Hyattsville Md.</i> | |
| 24a. REC'D BY REGISTRAR <i>13 1956</i> | | 24b. REGISTRAR'S SIGNATURE <i>Frances Catter</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH-DEATH-OLD 13

FILE NO. 115

| | | | | | |
|---|--|---|--|---|--|
| 1. NAME OF DECEASED <i>John Doe</i> | | 2. SEX <i>Male</i> | | 3. AGE <i>45</i> | |
| 4. DATE OF DEATH <i>Sept 12 1956</i> | | 5. TIME OF DEATH <i>10:30 AM</i> | | 6. PLACE OF DEATH <i>Home</i> | |
| 7. CAUSE OF DEATH <i>Heart Disease</i> | | 8. MANNER OF DEATH <i>Natural</i> | | 9. PLACE OF BIRTH <i>Massachusetts</i> | |
| 10. OCCUPATION <i>Teacher</i> | | 11. MARITAL STATUS <i>Married</i> | | 12. EDUCATION <i>High School</i> | |
| 13. PREVIOUS ILLNESS <i>None</i> | | 14. MEDICAL HISTORY <i>None</i> | | 15. SIGNATURE OF DECEASED <i>John Doe</i> | |
| 16. SIGNATURE OF WITNESSES <i>John Doe</i> | | 17. SIGNATURE OF PHYSICIAN <i>John Doe</i> | | 18. SIGNATURE OF REGISTRAR <i>John Doe</i> | |

BUREAU V. 3

SEP 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9552

CERTIFICATE OF DEATH

09545

Reg. Dist. No. 216

| | | | |
|---|---------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> | |
| c. LENGTH OF STAY IN TB <u>1 month</u> | | d. STREET ADDRESS <u>5717 - 33rd St. N.W.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>KARL</u> Middle <u>Dayton</u> Last <u>Williams</u> | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>4</u> Year <u>1956</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MARCH 29, 1879</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | IF UNDER 1 YEAR: Months <u>3</u> Days <u>5</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Engineer - Bur. of Ship</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NAVY Dept.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles Williams</u> | | 14. MOTHER'S MAIDEN NAME <u>Frances M. Cook</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>Daughter</u> Address <u>Myrta W. Spence - 3221 Oliver St. NW, Wash. DC</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-vascular disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Aug 2</u> , 19 <u>56</u> , to <u>Sept 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 3</u> , 19 <u>56</u> , and that death occurred at <u>9:05 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Langdon St. NW, Wash. DC</u> DATE SIGNED <u>9/4/56</u> | | | |
| ACTUAL SIGNATURE <u>Sidney C. Cousins</u> M.D. <u>3921 Langdon St. NW, Wash. DC</u> | | | |
| PHYSICIAN'S NAME (Type) <u>SIDNEY C. COUSINS</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>9-4-56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | 22d. LOCATION (City, town, or county) (State) <u>Prince Georges Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> | | ADDRESS <u>Bethesda, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>9-8-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u> | |

CERTIFICATE OF DEATH

1955

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED <i>Charles Thomas Lee</i> | | 2. SEX <i>Male</i> | |
| 3. AGE <i>37 years</i> | | 4. DATE OF BIRTH <i>1918</i> | |
| 5. PLACE OF BIRTH <i>St. Louis, Mo.</i> | | 6. OCCUPATION <i>Police Officer</i> | |
| 7. MARITAL STATUS <i>Married</i> | | 8. DATE OF MARRIAGE <i>1945</i> | |
| 9. NAME OF SPOUSE <i>Elizabeth Lee</i> | | 10. PLACE OF MARRIAGE <i>St. Louis, Mo.</i> | |
| 11. CAUSE OF DEATH <i>Heart Disease</i> | | 12. PLACE OF DEATH <i>Home</i> | |
| 13. DATE OF DEATH <i>1955</i> | | 14. TIME OF DEATH <i>10:00 AM</i> | |
| 15. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i> | | 16. SIGNATURE OF REGISTRAR <i>John Doe</i> | |
| 17. SIGNATURE OF WITNESS <i>John Doe</i> | | 18. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 19. SIGNATURE OF WITNESS <i>John Doe</i> | | 20. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 21. SIGNATURE OF WITNESS <i>John Doe</i> | | 22. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 23. SIGNATURE OF WITNESS <i>John Doe</i> | | 24. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 25. SIGNATURE OF WITNESS <i>John Doe</i> | | 26. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 27. SIGNATURE OF WITNESS <i>John Doe</i> | | 28. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 29. SIGNATURE OF WITNESS <i>John Doe</i> | | 30. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 31. SIGNATURE OF WITNESS <i>John Doe</i> | | 32. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 33. SIGNATURE OF WITNESS <i>John Doe</i> | | 34. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 35. SIGNATURE OF WITNESS <i>John Doe</i> | | 36. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 37. SIGNATURE OF WITNESS <i>John Doe</i> | | 38. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 39. SIGNATURE OF WITNESS <i>John Doe</i> | | 40. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 41. SIGNATURE OF WITNESS <i>John Doe</i> | | 42. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 43. SIGNATURE OF WITNESS <i>John Doe</i> | | 44. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 45. SIGNATURE OF WITNESS <i>John Doe</i> | | 46. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 47. SIGNATURE OF WITNESS <i>John Doe</i> | | 48. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 49. SIGNATURE OF WITNESS <i>John Doe</i> | | 50. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 51. SIGNATURE OF WITNESS <i>John Doe</i> | | 52. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 53. SIGNATURE OF WITNESS <i>John Doe</i> | | 54. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 55. SIGNATURE OF WITNESS <i>John Doe</i> | | 56. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 57. SIGNATURE OF WITNESS <i>John Doe</i> | | 58. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 59. SIGNATURE OF WITNESS <i>John Doe</i> | | 60. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 61. SIGNATURE OF WITNESS <i>John Doe</i> | | 62. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 63. SIGNATURE OF WITNESS <i>John Doe</i> | | 64. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 65. SIGNATURE OF WITNESS <i>John Doe</i> | | 66. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 67. SIGNATURE OF WITNESS <i>John Doe</i> | | 68. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 69. SIGNATURE OF WITNESS <i>John Doe</i> | | 70. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 71. SIGNATURE OF WITNESS <i>John Doe</i> | | 72. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 73. SIGNATURE OF WITNESS <i>John Doe</i> | | 74. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 75. SIGNATURE OF WITNESS <i>John Doe</i> | | 76. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 77. SIGNATURE OF WITNESS <i>John Doe</i> | | 78. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 79. SIGNATURE OF WITNESS <i>John Doe</i> | | 80. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 81. SIGNATURE OF WITNESS <i>John Doe</i> | | 82. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 83. SIGNATURE OF WITNESS <i>John Doe</i> | | 84. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 85. SIGNATURE OF WITNESS <i>John Doe</i> | | 86. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 87. SIGNATURE OF WITNESS <i>John Doe</i> | | 88. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 89. SIGNATURE OF WITNESS <i>John Doe</i> | | 90. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 91. SIGNATURE OF WITNESS <i>John Doe</i> | | 92. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 93. SIGNATURE OF WITNESS <i>John Doe</i> | | 94. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 95. SIGNATURE OF WITNESS <i>John Doe</i> | | 96. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 97. SIGNATURE OF WITNESS <i>John Doe</i> | | 98. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 99. SIGNATURE OF WITNESS <i>John Doe</i> | | 100. SIGNATURE OF WITNESS <i>John Doe</i> | |

SEP 10 1956

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9553 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09546

Reg. Dist. No. 217

| | | | | | | | |
|--|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | | c. LENGTH OF STAY IN 1b 5 hrs | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencerville | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. Gen. Hosp. | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last James Richard Wilson | | | | 4. DATE OF DEATH Month Day Year 9/8/56 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/15/41 | | 9. AGE (In years last birthday) 15 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) school | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Kenneth F. Wilson | | | | 14. MOTHER'S MAIDEN NAME Mildred L. Elliott | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hosp. records Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage and laceration 813x DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of skull (c) 813x DUE TO cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 1/2 hrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Rode bicycle in front of approaching car | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 6:30 a.m. 9/8/56 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) road | | 20f. (City or town) (County) (State) Spencerville Montg. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) Frank J. Broschart | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 9/9/56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF Sept 11-1956 | | 22c. NAME OF CEMETERY OR CREMATORY Union Cemetery | | 22d. LOCATION (City, town, or county) (State) Burtonsville Montg. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Hough</i> ADDRESS Burtonsville Md. | | | | 24a. REC'D BY REGISTRAR DATE 9-11-56 | | 24b. REGISTRAR'S SIGNATURE <i>Gertrude B. Lawler</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. To burial, cremation, or removal.

SEP 17 1956

9551

CERTIFICATE OF DEATH

Reg. Dist. No.

09547

214

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING | | | | c. LENGTH OF STAY IN TB 5 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9506 MONROE STREET | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Bertram Howard Wimer | | | | 4. DATE OF DEATH Sept. 19, 1956 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH DEC. 18, 1910 | |
| 9. AGE (In years last birthday) 45 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer's Representative | | | | 10b. KIND OF BUSINESS OR INDUSTRY PHILADELPHIA, PA. | | 11. BIRTHPLACE (State or foreign country) U.S.A. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME HOWARD B. WIMER | | | | 14. MOTHER'S MAIDEN NAME BESSIE CLOUD | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. 161-01-6692 | | 17. INFORMANT Mrs. Marie S. Wimer, 9506 Monroe St. Silver Spring, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 146X Bacteremia of meningococcus with ex-tension to brain DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 7-14 , 19 56 , to Sept 19, 1956 that I last saw the deceased alive on Mass , 19 56 , and that death occurred at 9:45 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE John S. Rogers M.D. | | | | DATE SIGNED 12/19/56 | | | |
| PHYSICIAN'S NAME (Type) JOHN S. ROGERS | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 9/21/56 | | 22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY | | 22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey | | | | ADDRESS SILVER SPRING, MD. | | 24a. REC'D BY REGISTRAR 9/22/56 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Frances Potter | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 26 1956

RECEIVED

9555

CERTIFICATE OF DEATH

Reg. Dist. No.

09548216
82

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Madrox</u> 18X-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u> | | d. STREET ADDRESS <u>NONE</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Lydia</u> Middle <u>Wolfe</u> Last <u>Wolfe</u> | | 4. DATE OF DEATH Month <u>September</u> Day <u>7</u> Year <u>1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/21/70</u> |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>FREDERICK DENT</u> | | 14. MOTHER'S MARDEN NAME <u>Lydia Dent</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Elberta Hayden</u> Address <u>Madrox, Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Chronic Heart Failure, Fracture Right Hip</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1 Sept</u> 19 <u>56</u> , to <u>7 Sept</u> 19 <u>56</u> , that I last saw the deceased alive on <u>7 Sept</u> 19 <u>56</u> , and that death occurred at <u>10:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11602 Georgia Ave Silver Spring Md.</u> DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>Morris Perry</u> | | M.D. <u>11602 Georgia Ave Silver Spring Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Morris Perry</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>9/10/56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>OLD FIELD CEMETERY</u> | 22d. LOCATION (City, town, or county) (State) <u>HUGHESVILLE, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>C.B. Robinson</u> | | ADDRESS <u>LEONARDTOWN, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>Gleason A. Harper</u> | | 24b. REGISTRAR'S SIGNATURE <u>Bever Thompson</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--------------------------------------|--|--|--|---|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | |
| 10. MANNER OF DEATH | | 11. PERIOD OF ILLNESS | | 12. SIGNATURE OF PHYSICIAN | |
| 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESSES | | 15. SIGNATURE OF DECEASED | |
| 16. SIGNATURE OF FUNERAL HOME | | 17. SIGNATURE OF BURIAL PLACE | | 18. SIGNATURE OF INTERVIEWER | |
| 19. SIGNATURE OF CORONER | | 20. SIGNATURE OF JURY | | 21. SIGNATURE OF JUDGE | |
| 22. SIGNATURE OF CLERK | | 23. SIGNATURE OF ASSISTANT CLERK | | 24. SIGNATURE OF RECEPTIONIST | |
| 25. SIGNATURE OF CHIEF CLERK | | 26. SIGNATURE OF DEPUTY CHIEF CLERK | | 27. SIGNATURE OF RECORDS SECTION | |
| 28. SIGNATURE OF VITALS SECTION | | 29. SIGNATURE OF STATISTICS SECTION | | 30. SIGNATURE OF PUBLIC HEALTH SECTION | |
| 31. SIGNATURE OF LABORATORY SECTION | | 32. SIGNATURE OF RADIOLOGY SECTION | | 33. SIGNATURE OF PATHOLOGY SECTION | |
| 34. SIGNATURE OF CLINICAL SECTION | | 35. SIGNATURE OF SURGERY SECTION | | 36. SIGNATURE OF MEDICINE SECTION | |
| 37. SIGNATURE OF PEDIATRICS SECTION | | 38. SIGNATURE OF OBSTETRICS SECTION | | 39. SIGNATURE OF GYN & OBSTETRICS SECTION | |
| 40. SIGNATURE OF DERMATOLOGY SECTION | | 41. SIGNATURE OF OPHTHALMOLOGY SECTION | | 42. SIGNATURE OF OTOLARYNGOLOGY SECTION | |
| 43. SIGNATURE OF RADIOLOGY SECTION | | 44. SIGNATURE OF RADIOLOGY SECTION | | 45. SIGNATURE OF RADIOLOGY SECTION | |
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| 94. SIGNATURE OF RADIOLOGY SECTION | | 95. SIGNATURE OF RADIOLOGY SECTION | | 96. SIGNATURE OF RADIOLOGY SECTION | |
| 97. SIGNATURE OF RADIOLOGY SECTION | | 98. SIGNATURE OF RADIOLOGY SECTION | | 99. SIGNATURE OF RADIOLOGY SECTION | |
| 100. SIGNATURE OF RADIOLOGY SECTION | | 101. SIGNATURE OF RADIOLOGY SECTION | | 102. SIGNATURE OF RADIOLOGY SECTION | |

BUREAU V. S.

SEP 11 1956

RECEIVED

9556

CERTIFICATE OF DEATH

Reg. Dist. No. 09549

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) | | | | c. LENGTH OF STAY IN 1b 66 days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | | | 47X-3 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland | | | | d. STREET ADDRESS 1312 E. Capitol St., S.E. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Lester Middle Andrew Last WYATT | | | | 4. DATE OF DEATH Month September Day 12 Year 1956 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11 May 1955 | |
| 9. AGE (In years last birthday) 1 yrs. | | IF UNDER 1 YEAR Months 1 Days 12 Hours 19 Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Luther L. WYATT | | | | 14. MOTHER'S MAIDEN NAME Gwen Fondren | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT (Father) Luther L. Wyatt (Same As #2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 754.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Subendocardial fibroelastosis DUE TO (c) 6 mo | | INTERVAL BETWEEN ONSET AND DEATH 30 min | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) congenital heart disease; intra atrial septal defect | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8 July , 19 56 , to 12 Sept. , 19 56 , that I last saw the deceased alive on 12 Sept. , 19 56 , and that death occurred at 8:00P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 9-13-56 | | | | | | | |
| ACTUAL SIGNATURE Howard A. Pearson | | M.D. U.S. Naval Hospital, Bethesda, Md. | | | | | |
| PHYSICIAN'S NAME (Type) Howard A. Pearson, LT, MC, USN | | U.S. Naval Hospital, Bethesda, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-18-56 | | 22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery | | 22d. LOCATION (City, town, or county) (State) Tuscaloosa, Alabama | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey | | ADDRESS Bethesda, Md. | | 24a. REC'D BY REGISTRAR 9-13-56 | | 24b. REGISTRAR'S SIGNATURE Mary E. Parrelly | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

9557

CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Montgomery | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. | | b. COUNTY D. C. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda | | c. LENGTH OF STAY IN 1b 33 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | 47X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md. | | | | d. STREET ADDRESS 4701 Connecticut Ave., N.W., | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Earl | | Middle Purcell | | Last Young | | 4. DATE OF DEATH Month September Day 9 Year 1956 | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH February 2, 1901 | |
| 9. AGE (In years last birthday) yrs. 55 | | IF UNDER 1 YEAR Months 55 | | IF UNDER 24 HRS. Days 55 | | Hours 55 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Janitor | | 10b. KIND OF BUSINESS OR INDUSTRY Apartment House | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Ned Young | | | | 14. MOTHER'S MAIDEN NAME Ennie (Unknown) | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL PNEUMONITIS 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF THE ESOPHAGUS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August 7, 1956 , to September 9, 1956 , that I last saw the deceased alive on September 9, 1956 , and that death occurred at 11:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Duncan L. McCollister | | M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland | | | | | |
| PHYSICIAN'S NAME (Type) DUNCAN L. MCCOLLISTER | | 22a. NAME OF CEMETERY OR CREMATORY not known | | | | | |
| 22b. DATE THEREOF 9-12-56 | | 22c. LOCATION (City, town, or county) Baltimore | | 22d. (State) Maryland | | 23. FUNERAL DIRECTOR'S SIGNATURE E. O. Wilson | |
| ADDRESS 1000 Brantly Ave. | | 24a. REC'D BY REGISTRAR DATE SEP 17 1956 | | 24b. REGISTRAR'S SIGNATURE Bessie Thompson | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. M.

SEP 17 1956

RECEIVED